Violence, injury and child safety: The new challenge for child health

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Large numbers of children die each year from violence and injuries, while many more suffer resultant physical disability and mental health problems.[1] The burden of violence and injury among children and adolescents is greatest in low- and middle-income countries which account for 80 – 95% of fatalities globally.[2] In South Africa, injuries make up an increasing proportion of child deaths and are the leading cause of death amongst adolescents. In addition, non-fatal injuries contribute to a growing burden of disability in childhood, are concentrated among poor children, and increase as children age. Despite this growing public health problem, a coordinated focus on injury and violence has not been prioritised by the state or the health sector.[3]

Violence (intentional injuries) and unintentional injuries share some common risk factors such as poverty, poor education, and substance and alcohol use, among others. However, unintentional injury prevention and control have mainly been addressed from a biomedical approach with a limited recognition of the common risks, long-term psychosocial consequences beyond the injuries, and a lack of intersectoral responses to address the burden. There is an opportunity to bridge this divide, particularly considering common approaches to intervene through communities and parents to develop safe, stable and healthy relationships with young children to reduce the effects of trauma, the ongoing exposure to unintentional injury, as well as the intergenerational effects of violence.

Global and local policy initiatives, including the Sustainable Development Goals (SDGs) adopted by all United Nations member states in 2015, have set targets for the prevention of violence and injury. Such initiatives offer an opportunity to strengthen intersectoral collaboration and create a safe environment by e.g. addressing poverty and inequality and promoting safe energy across settings (in homes, schools and communities). The SDGs and other initiatives also include targets to reduce specific forms of injuries and violence.[4] But, these efforts will only succeed if government makes child safety a priority.

This chapter focuses on violence and injuries during childhood and adolescence and addresses the following:

- What do we mean by intentional and unintentional injuries?
- What do we know about the extent and causes of childhood injuries?
- How does the pattern of childhood injury change across the life course?
- What are the key common and injury specific risk and protective factors?
- What are the opportunities for intervention?
- What are the implications of current knowledge for the policies and programmes that are in place?
- What is needed to promote a coordinated national child safety agenda?

What do we mean by intentional and unintentional injuries?

The field of injury prevention includes both violence and injury, but they have emerged as two distinct areas globally and in South Africa. The World Health Organization's framework and injury classification make a distinction between unintentional and intentional injuries. Intentional injuries are those that are deliberately inflicted and include self-inflicted, interpersonal and collective violence. Unintentional or "accidental" injuries are sustained in the absence of an intention to harm and are usually classified according to their causal mechanism – the most-common causes include road traffic injuries, falls, burns and scalds, drowning and poisonings.

The term 'accident' is often colloquially used to refer to the inevitability of events that lead to an injury. This is however contrary to a growing body of evidence that highlights the preventable nature of an injury event and therefore the term unintentional injury is better aligned to a prevention agenda.[5] Injury is therefore classified as either intentional or unintentional; yet these categories are often not as distinct as they are made out to be.[6] There are many connections that exist between the two problems, such as similar associated

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factors, common consequences, and common prevention measures.[7] For example, the distinction between inadequate supervision and deliberate neglect may require careful investigation to establish the circumstances and history of the injury, as illustrated in Case 1. A history of injuries that at first sight may look unintentional is often a sign of abuse and neglect. For example, the Child Death Review Project found that 11% of out-of-hospital child deaths were associated with child abuse.[8] Decisions to define injuries as unintentional are often made without sufficient consideration of the social and structural factors that may lead or contribute to an injury. Such factors may also include harmful practices sanctioned by the state or industry, for example, the production, marketing and use of dangerous paraffin stoves.[9]

What do we know about the extent and nature of violence and injuries?

Despite extensive global and national policy frameworks, South Africa's children continue to be threatened by both intentional and unintentional injuries.

Mortality rates

Injury is a leading cause of death and disability amongst children and adolescents, with a global annual child-injury mortality of 8.6 per 100,000 in high-income countries compared with 41.8 per 100 000 in low- and middle-income countries.[10] Injury deaths in South Africa are high at a rate of 38.9 per 100,000 for children 19 years and younger.[11] Since 2000, injury mortality rates have declined for both adults and children;[12] yet the recent escalation in homicides[13] and persistently high levels of road traffic mortality[14] are causes for concern. The second National Burden of Disease Study indicates that child injury deaths are concentrated among children under five years old and among older adolescents.[15] Globally, the contribution of injury deaths to under-five mortality is increasing as child mortality from communicable diseases declines.[16]

The leading causes of child injury deaths in South Africa are road traffic injuries (36.0%), homicide (28.2%), other unintentional injuries such as burns and drowning (27.3%), and suicide (8.5%). The causes of injury mortality vary by age as illustrated in Table 14.

Deaths due to road traffic and other unintentional injuries (especially burns and drowning) are most concentrated among young, pre-school children.[17] Deaths due to road traffic injuries are higher than global rates particularly for ages 0 – 4 years, at 15 per 100,000 children;[18] but decline to 10.4 per 100,000 for 5 – 14-year olds; and then escalate to peak amongst older adolescents, with a rate for 15 – 29-year-olds at 39.7 per 100,000[19].

Deaths due to other unintentional injuries also tend to decline after the first four years,[20] e.g. the highest childhood burn mortality rates are reported in the under-five age group and thereafter rates decrease until adolescence when burn mortality rates start to increase again into adulthood.[21] There appears to be a similar pattern for drowning deaths, with a provincial study reporting a decline after early childhood and a slight increase in rates during adolescence.[22]

Child homicides are classified as intentional injuries and the pattern reflects an initial peak amongst infants, followed by a decline and then a significant increase among older adolescents and into adulthood. The South African child homicide rate of 5.5 per 100,000 children[23] is significantly higher than the estimated global rate of 4 per 100,000 children.[24] Nearly half (44.6%) of child homicides were associated with child abuse and neglect and nearly three-quarters (74%) of these child abuse deaths were in the under-five age group and occurred in the home.[25] Rape-murder rates are high at 1.03 per 100,000 girls, and with older adolescent girls most at risk from known perpetrators.[26] The homicide rate from early adolescence increases eight fold among older adolescents and mainly affects males.[27] Adolescent males are mainly killed in public spaces, and with the perpetrator known to them, and have much higher mean blood alcohol (0.10g/100ml) than adolescent females.[28]

Case 9: Investigating cause of death – unintentional or intentional injury?

An 18-month-old child was brought to Salt River mortuary after a fatal hit-and-run road traffic accident. The autopsy confirmed a severe head injury and he died on the scene at 21.00 hours on a Wednesday evening. The case was reviewed by the Child Death Review team to determine the circumstances that led to his death and whether there were any modifiable factors. The review established that the child was walking on his own at 21.00 hours. His mother had been drinking since the afternoon with friends and the child was left roaming the street unattended. The case was investigated by Department of Social Development for deliberate neglect – highlighting the difficulty in distinguishing between intentional and unintentional injuries in children.

Source: Unpublished data from the Child Death Review Project, Children's Institute, University of Cape Town.

Suicide first manifests in early adolescence, and then increases in older adolescence,[29] although recent data from the Child Death Review Project reveals a worrying trend with children as young as nine years old committing suicide.[30] The available rates for child mortality are not consistently reported, with rates from the most-recent Injury Mortality Survey in 2009 now dated and limited in its presentation of age categories that differ from international age ranges.

Non-fatal injuries

Fatal injuries are considered to be the "tip of an iceberg". For example, in the United States, childhood injury surveillance data show that, for every unintentional injury death amongst young people, there are 33 hospitalisations and 1,053 emergency department visits.[31] Furthermore, one in four children in the United States are injured severely enough to miss school or require medical attention or bed rest.[32]

South African routine hospital injury surveillance data are limited. ChildSafe, based at Red Cross War Memorial Children's Hospital drawing in the City of Cape Town Metro West catchment area, is the only child injury surveillance system in the country that monitors child injury trends, but only includes children to the age of 12 years. This data source over time provides trend descriptions of the most important forms of injury and information on their occurrence and can alert the City authorities to emerging priorities, all vital for timely prevention.

As with most non-fatal injury information systems and studies, there are limitations to the ChildSafe data. It has an urban bias and does not capture unintentional and intentional injuries during adolescence due to the age cut off. ChildSafe is also located at a specialised, tertiary hospital and thus receives referrals beyond its catchment area, making population-based rates a challenge. Nevertheless, hospital surveillance systems are important, as the leading causes of hospitalisation differ from the causes of fatal injuries.[33]

Table 15 indicates that falls, pedestrian traffic injuries, scalding burns and "being struck" are amongst the primary reasons for hospitalisation, with the numbers of pedestrian injuries in particular appearing to be on the increase. Unlike the ChildSafe surveillance system, most information systems are injury specific. Hence there is still a need for a comprehensive coverage of non-fatal injuries, considering their extensive occurrence and their long-term physical, psychosocial and economic consequences.

Injury surveillance systems under-report child maltreatment, therefore dedicated studies are needed to provide a more comprehensive understanding of the nature and magnitude of violence against children. These studies indicate that violence during childhood is widespread, with 42% of children reporting some form of maltreatment in the first national prevalence study.[34] Violence is conceptualised as: physical abuse, sexual abuse, emotional abuse which all intersect. Importantly, these forms of violence may co-occur. Violence also includes sexual exploitation, cultural practices and corporal punishment.

There is no routine data source that tracks the incidence of violence against children and most data sources thus underestimate the extent of the problem. Children lack the capacity to report and often a perpetrator is someone close to the child, limiting the child's ability to speak up to end the abuse. In addition, injuries due to violence are often not reported and missed as a case of abuse, therefore limiting data on the incidence of child abuse.

Table 14: Causes of child injury deaths, by age, 2009

	Road traffic deaths	Other unintentional injuries	Homicide	Suicide	Total injury deaths
< 1 year	132	239	160	-	531
1 – 4 years	609	806	126	-	1,541
5 – 9 years	615	422	83	-	1,120
10 – 14 years	433	286	203	127	1,049
15 – 19 years	1,094	434	1,683	554	3,765
Total injuries	**2,883**	**2,187**	**2,255**	**681**	**8,006**[i]

Source: Matzopoulos R, Prinsloo M, Bradshaw D, Pillay-van Wyk V, Gwebushe N, Mathews S, Martin L, Laubscher R, Lombard C & Abrahams N (2013) *The Injury Mortality Survey: A national study of injury mortality levels and causes in South Africa in 2009*. Report for the national and provincial Departments of Health. South African Medical Research Council.

i 359 undetermined deaths excluded.

Table 15: ChildSafe injury surveillance, 2015 – 2018

Type of injury	2015	2016	2017	2018
Road traffic injury				
Pedestrian	783	742	606	892
Passenger: restrained	44	38	48	15
Passenger: unrestrained	130	127	120	88
Passenger: bakkie/minibus	89	68	52	56
Cycle	78	51	51	36
Other	22	18	20	10
Total	1,146	1,044	897	1,097
Assault				
Blunt	171	165	127	147
Sharp	39	29	30	16
Rape/sexual assault	82	58	45	84
Other	30	28	26	19
Total	322	280	228	266
Burn				
Flame	130	80	76	80
Fluid	1,565	1,037	957	892
Heat contact	73	72	83	80
Electrical	31	40	18	27
Explosion	15	16	11	7
Other (incl. chemical)	37	39	22	31
Total	1,851	1,284	1,167	1,117
Fall				
Off bed	332	259	381	372
Stairs/steps	170	196	180	166
Attendant's arms	74	70	92	89
Playground equipment	503	565	439	338
Mobiles	113	176	206	141
Other heights	429	561	424	404
Other	1,005	1,090	1,045	1,240
Total	2,626	3,017	2,767	2,750
Miscellaneous				
Struck by/against	601	648	617	590
Other cause	1,003	1,157	1,126	1,174
	1,604	1,805	1,743	1,764
Unknown	160	111	162	134
Total	7,709	7,541	6,964	7,128

Source: Data provided by ChildSafe South Africa (www.childsafe.org.za).

How does the pattern of childhood injury change across the life course?

The settings in which children are exposed to injury, the patterns of injury and associated risk factors change across the life course depending on the child's developmental phase. As children become more independent and move out of home into schools and the wider community, their safety is increasingly challenged by factors outside the home and parental control.

Infants and young children

Infants and young children are particularly vulnerable to injuries within the home and at early childhood development (ECD) centres where they depend on adult caregivers to provide care, supervision and a safe environment in which to explore. Developmentally younger children suffer injuries in the home due to their increased curiosity, activeness and interest in exploring their surroundings – falls, burns, fires, drowning, poisoning and physical abuse (including corporal punishment) and witnessing domestic violence all affect children of this age group.

Infanticide (the killing of an infant in the first year of life) is common in South Africa. The country's infanticide rate of 28.4 per 100,000 live births is one of the highest reported rates globally and infants are most at risk in the first six days of life.[35] Flame and hot water burns are also concentrated in this age group[36] where inadequate care and toddlers' increasing mobility and limited capacity to anticipate danger place them at risk. Informal dwellings and overcrowded living conditions also increase the risk of poisoning, falling, and drowning. Similarly, without adequate supervision and safe playgrounds, young children venture out into the roads and, due to their inability to anticipate traffic dangers, are at risk of road traffic injury. Physical punishment and domestic violence are the most-common forms of violence experienced and/or witnessed by young children, with long-lasting negative effects on their mental health.[37]

School-age children

School-age children (6 – 12 years) are at increased risk of road traffic injuries while travelling to school as passengers and pedestrians. Many children walk to and from school without adult supervision, and children are particularly vulnerable in informal settlements or poorly maintained neighbourhoods where the absence of pavements and poor enforcement of road traffic legislation increases the risk of pedestrian injury (Table 16).

Corporal punishment, bullying and sexual violence are common in South African schools. Sexual, physical and

Table 16: Primary settings and main types of injuries at different stages of development

Developmental stage	Primary settings	Intentional injuries	Unintentional injuries
Early childhood (0 – 5 years)	• Home • ECD centres • Roads and travel paths	• Infanticide • Physical abuse including corporal punishment	• Burns • Falls • Road traffic • Drowning
Middle childhood (6 – 12 years)	• Home • Primary school • Roads and travel paths	• Sexual abuse • Bullying • Corporal punishment at home and/or school	• Road traffic
Adolescence (13 – 19 years)	• Home • High school • Roads and travel paths • Recreational spaces	• Sexual abuse • Peer-on-peer violence • Gang violence • Suicide • Intimate partner violence	• Road traffic • Drowning

psychological violence occur across a range of settings – including the home, school and community. School-age children are therefore at increased risk of sexual violence from both known and unknown perpetrators. Girls and boys are equally at risk.[38]

Adolescents

Adolescents (13 – 19 years) are at an increased risk for road traffic injuries with the highest number of such deaths occurring between ages 15 and 19 years. Despite their increasing physical and cognitive capacities, adolescents are still at risk because they may overestimate their ability to negotiate often complex and hazardous traffic environments, while risk-taking behaviour is also a mark of this age group.[39]

At the same time, the risk of violent injury and homicide intensifies among adolescent boys, who are more likely to be victims of interpersonal violence in community settings. These risks increase due to young men's involvement in fights and the ready use of weapons linked to ideals of what it means to be a man. Conversely, teenage girls may experience early forms of intimate partner violence in dating relationships and sexual violence, mainly by known perpetrators, can occur across settings. Large numbers of South Africa's girls report that their first sexual experience was forced or coerced, yet many girls and boys do not consider this as sexual violence as they view such behaviour as a norm in intimate relationships.[40]

These injuries may result in varying degrees of disability and psychological harm,[41] with long-lasting educational, social and economic consequences for the affected individuals and their families. To prevent these long-term negative consequences, it is critical that emergency medical services are accessible, and that rehabilitation and therapeutic services are prioritised to reduce physical and mental effects. While the actual costs associated with childhood injuries are relatively unknown, the estimated costs of medical treatment, rehabilitation and administration may run into billions of Rands.[42] A recent costing study focused on the social and economic impact of violence against children and noted that preventing children from witnessing family violence and experiencing violence or neglect could lead to a 14% reduction in later drug abuse, 23% reduction in self-harm, 10% reduction in anxiety, 14% reduction in alcohol abuse and 16% reduction in interpersonal violence. The failure to prevent violence against children was estimated to cost nearly 5% of South Africa's gross domestic product in 2015.[43]

What are the key risk factors?

The determinants of injuries and violence are complex but understanding what increase the risk for children to experience injuries and violence can help to identify target prevention interventions. The socio-ecological model recognises that children's exposure to injury (and specific types of injury) and violence is influenced by a host of interrelated factors such as their individual attributes; evolving capacities; and the physical, social and cultural environments in which they live, learn and play.

This model emphasises that no single factor can explain why some children may be more vulnerable to injury than others, or why injury may be more prevalent in some settings or communities. Rather, injury is the result of the complex interplay of individual, relationship, community, cultural and historical factors. Understanding how these factors contribute to child injuries is an important step in the development of appropriately targeted prevention interventions. Ideally these should recognise the multi-faceted causes of injury and adopt a multi-sectoral and multi-disciplinary approach, including policy and legislative measures to ensure a coordinated and cohesive response.

Cross-cutting risks

There is recognition that some risks may contribute to more than one – if not all – types of injury, irrespective of cause, and even to other health and social conditions beyond injury (see Figure 36). These may signify key underlying social or structural causes that may underpin, and in part may explain, the pervasiveness of child vulnerability in South Africa.[44]

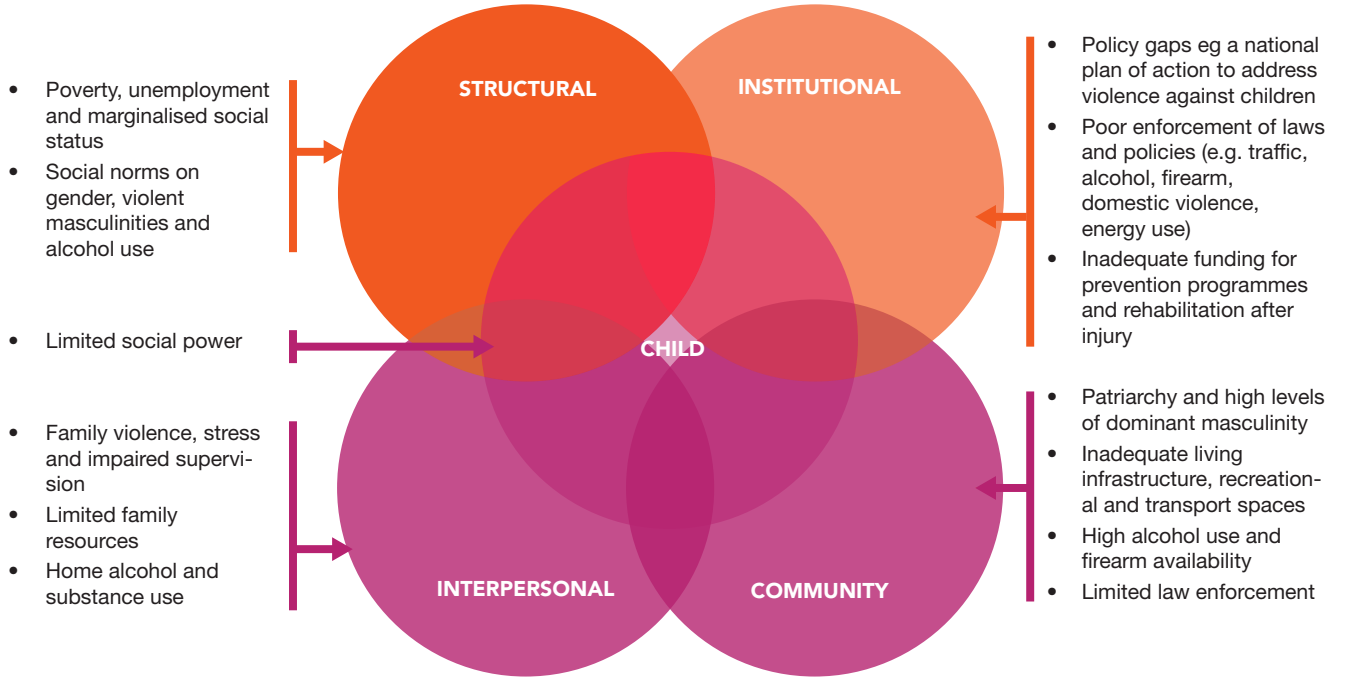
Such underlying causes include high levels of poverty and socio-economic inequality. With unemployment increasing to 29% [45] in 2019, poverty and inequality are crucial social dynamics that contribute to the marginalisation of communities and the consequent burden of stress on affected families. Income inequality, low economic development, in combination with high levels of gender inequity, are strong positive predictors of rates of violence, including homicides and major assaults, but also increase children's vulnerability to various unintentional injuries such as road traffic, poisoning and burn injuries.[46] The lack of adequate community infrastructure, including housing, community, transport routes and energy access, and the consequent impoverishment, may compound the risk for all injuries, and arguably impair family efforts to prevent or address these.

In South Africa, gender inequality is illustrated by high levels of violence against women and children and the recent gruesome accounts of femicide, rape and sexual assaults in the news media. The dominant constructions of masculinity in South Africa has been shown to emphasise competition between men, ready use of violence to defend honour, and heavy use of alcohol which often fuels violent behaviour.[47] These readily translate into risk-taking behaviours that result in injuries, including road traffic injuries and drowning, with both argued to result from enactments of toughness and risk-taking.[48]

The hazards faced by families are compounded by the widespread use of alcohol and substances – South Africa reports a high prevalence of harmful and hazardous use of alcohol and a high consumption of illicit drugs.[49] These contribute to homicides, intimate partner violence, rape, abuse of children, road deaths, and other unintentional injuries such as burns. Furthermore, South Africa has a wide availability of firearms, an entrenched gun culture, and such weapons are used at home often to threaten and exert power and control over women and families. This raises concerns about the increasing direct and indirect impact on child injury and long-term physical and emotional harm.

Furthermore, law enforcement is often weak, with many crimes going unpunished especially in poor communities where police services are under-resourced. Similarly, on the roads, there has been a similar reluctance to enforce safety measures, especially where it involves the powerful taxi industry, and there has been little regulation of the manufacture and sale of unsafe and potentially harmful home appliances often

Figure 36: Common cross-cutting risks for child injury and violence



Source: Maternowska MC & Potts A (2017) *The Multi-Country Study on the Drivers of Violence Affecting Children: A child-centred integrated framework for violence prevention*. Florence, Italy: UNICEF Office of Research.

Table 17: Risk and protective factors for burns

Individual factors	Relationship factors	Community factors	Societal factors
Risk factors			
• Male children (0 – 4 years)	• Alcohol intoxication in caregivers • Psychosocial stress • Supervision barriers • High child–adult ratios	• Restricted home spaces • 1 – 2 rooms house and temporary room divisions • Rooms with multiple functions	• Low socio-economic status • Low literacy and income • Poor overall health status
Protective factors			
• Caregiver support	• Caregiver knowledge of child safety • Care support	• Larger homes • Multiple rooms, each with permanent designated function	• Middle- and high socio-economic status • High literacy levels • Good health status

used for cooking and heating by people living in poverty. These entrenched economic and social features of South Africa undermine the capacities of the state, communities and families to provide the requisite living spaces and care for children and are reflected in the widespread abuse and vulnerability of children and compounded by children's low status and lack of power in South African society.

More specific risk factors for burns, road traffic injury and violence are discussed below.

Factors for burns

Burn injury has been a persistent cause of child mortality and morbidity in South Africa, with past reports indicating up to 1,300 child deaths a year as a result of these injuries.[50] Serious burn injuries are concentrated in marginalised, low-income settings[51] where overcrowded and congested homes increase the risk of children coming into contact with candles, hot water or foodstuffs, and paraffin stoves;[52] and where care and supervision may be undermined by the competing demands of work, chores, child care, unexpected events and crises[53]. In smaller homes, including informal dwellings, limited space means children are in greater proximity to cooking areas, which is compounded in homes with increased numbers of children. Homes with more children may also reflect greater caretaking demands and stress.

Parent or caregiver sociodemographic factors such as gender, age, and especially education have been linked to child burns.[54] Such factors may affect caregiver supervision styles and underlying attitudes and beliefs, with increased supervision and closer proximity of caregivers to especially younger children associated with a lower risk of burns.[55] In other settings, parents reported that children were more at risk of injuries outside of the house (such as getting hit by a car or kidnapped), than from injuries in the house, such as burns.[56]

The home environment, across socio-economic classes, may therefore be assessed as less hazardous than open, public spaces and, as a result, caregivers may allow their children to play out of reach or unsupervised more often when inside the house. This elevates the child's risk in a small home where heating and cooking appliances are close to each other.

Factors for road traffic and pedestrian injuries

Pedestrian injury is the leading cause of injury mortality and morbidity amongst children. Rates of road traffic mortality are high amongst young children especially young boys[57] which may reflect patterns of child care and socialisation that allow boys greater autonomy.[58] One in five (21%) pedestrian fatalities involve children younger than 15 years.[59] This is unsurprising, given that 68% of South African children walk to and from school.[60] A study in Khayelitsha, Cape Town, reported a significant proportion of children walk to school unsupervised – often alone, young and with riskier road-crossing behaviour.[61]

The absence of adult supervisors, along with impairments in adult and child road safety knowledge are reported to place children at risk across settings.[62] The presence of significant environmental risks is reported to be amplified in lower-income neighbourhoods which may have fewer demarcated pedestrian pathways and crossing points, a greater density of children with more limited and secure play areas, and weaker law enforcement.[63] Environmental risk factors such as poor road infrastructure[64] and limited adult supervision (due to competing domestic or work demands) increase the risk of injury.[65]

There are also a multitude of societal risk factors that place children at risk of road traffic injuries, including higher normative levels of road rage, failure to enforce and/or comply with traffic rules, and driving under the influence of alcohol.[66] In general, children and young people living in working-class

Table 18: Risk and protective factors for road traffic injuries

Individual factors	Relationship factors	Community factors	Societal factors
Risk factors			
• 0 – 4 years: limited risk appraisal skills for complex road situations; evolving capacity to respond to hazards; smaller physique. • Male children: engagement in risk-taking	• Low socio-economic household • Barriers to adult supervision • Lack of education and road safety knowledge	• Low-income neighbourhoods: children cross streets more often, travel to school on foot • Limited crossing points and poor pedestrian pathways • Lack of law enforcement • Alcohol consumption	• Infrastructure: quality of road surface, traffic modes, vehicle conditions • Number of parked vehicles on a street, more than two travel lanes • High population density of children, absence of play areas • Road rage and anger
Protective factors			
• Adult supervision • Road safety knowledge	• Adult supervision • Educational programmes • Safety-oriented drivers • Appropriate child car seat restraint	• School transport system • Demarcated and protected pathways and play areas • Children in middle- or high-income neighbourhood • Effective law enforcement	• Living in a low-density area • Regular road and pathway maintenance • Law enforcement of unroadworthy vehicles • Norms on sober driving • Norms on non-aggression

neighbourhoods with limited land-use planning, pedestrian infrastructure, protected play areas, road and street lighting are at greater risk.

Factors for violence and abuse

Many of the factors that affect individuals' risks of violence and abuse result from early experiences. For example, children can be at greater risk of abuse if they are born to parents that are young, single, who suffer from mental health conditions or substance abuse, or where there is violence in the home.[67] The relationship between these early experiences and child abuse can stem from poor attachment between parents and children and harsh parenting in the context of limited financial resources and social support.[68]

These early experiences that children have also impact on their risks of involvement in violence in adolescence both as perpetrators and victims.[69] Sexual abuse features across the life course of a child but peaks among adolescent girls.[70] Sexual violence appear to be related to the broader context of gender inequality and the underlying system of patriarchy which drives violence against women and children.[71]

The Optimus Study, the first national violence prevalence study, found that physical abuse, emotional abuse, neglect, and family violence were all strongly associated with experience of sexual abuse. Key risk factors for sexual abuse include substance misuse by the child and/or caregiver, a poor relationship between the caregiver and child, poor knowledge of the child's whereabouts and activities, and high-risk sexual behaviour by the child.[72]

Adolescent males are more likely than females to be involved in peer-on-peer violence and also are at increased risk to be murdered than adolescent girls, with young men primarily killed in the context of male-on-male interpersonal violence. This appears to be linked to male risk-taking behaviour in adolescence and a culture of violence in communities where dominant notions of masculinity glamorise risk-taking and the use of violence.[73]

Adverse childhood experiences such as losing a parent or exposure to violence in the home are known risk factors for adolescent risk behaviour and later perpetration of violence.[74] Poverty, unemployment experienced as severe deprivation combined with disorganised family life also contribute to young men adopting violent behaviour which is based on notions of what it means to be a "real man" (masculinity) and patriarchy in South Africa.[75]

The experience of violence has immediate consequences, like injuries, but also significant long-lasting emotional and social consequences that drive an intergenerational cycle of violence. For example, children who are abused or who witness violence at home are at increased risk of youth violence and of both suffering and perpetrating intimate partner violence in adulthood.[76]

This cyclical nature of violence means that early primary prevention interventions that protect children from becoming victims or reduce violent behaviour can protect them from violence throughout life.

What are the opportunities for intervention?

Despite the many prevention programmes promoted by the World Health Organization (WHO) and other international and regional agencies, the evidence base for their effectiveness is mostly limited to interventions at the individual and

Table 19: Risk and protective factors for violence and abuse

	Individual factors	Relationship	Community factors	Societal factors
Child abuse (including fatal child abuse)	**Risk factors**			
	• Female • Neonatal period (infanticide) • Under five years old • Vulnerable groups include: premature infants, twins, and disabled children	• Young parents • Single parent families • Families with large number of children • Mothers with children at young age • Low socio-economic status • Low family cohesion • Substance use in the home	• High level of substance abuse in the community • High level of crime • Overcrowding • Poor/inadequate social services • High unemployment	• High levels of inequality and social exclusion • Patriarchal norms • Gender inequality • Social and cultural norms that permit corporal punishment
	Protective factors			
	• Intact families (well-structured households) • Secure attachment to parents	• Secure attachment to infant and child • Parents with supportive relationship with children • Parental monitoring and social support	• Cohesive communities with structures to support responsive policing and criminal justice system • Adequate child-care facilities • Supportive and safe school environment	• Economic empowerment programmes including job creation • Policies to regulate alcohol use • Social norms campaigns to address positive forms of parenting
Youth violence	**Risk factors**			
	• Male • Involvement in physical fights • Carrying weapons • Gang involvement • Not attending school • Substance abuse	• Bullying • Low family cohesion • Violence in the home (including child abuse)	• Peer pressure to use alcohol and drugs • Lack of positive peer group support • Violent communities with gang and gun violence • High unemployment • Communities with reduced social capital	• High levels of inequality and social exclusion • Patriarchal norms • Gender inequality and social exclusion • Social and cultural norms that condone the use of violence
	Protective factors			
	• Education • Reducing alcohol consumption	• Conflict management skills • Positive male role model in the home	• Strengthening interpersonal relations • Increase social interaction among other positive youths • Reducing availability of alcohol • Extracurricular activities such as sport • School connectedness	• Social norms campaigns that promote gender equity • Enforced criminal justice sanctions for perpetrators of violence • Policies to regulate gun control and substance abuse and their enforcement

relationship level which tend to be more affordable, easier to implement and easier to evaluate. There remains limited knowledge of "what works" in low- and middle-income settings.[77]

From treatment to primary, secondary and tertiary prevention

The WHO has released a series of reports on violence, traffic and child injury prevention, including the World Report on Child Injury Prevention,[78] the Global Status Report on Violence Prevention 2014,[79] the World Report on Road Traffic Injury Prevention,[80] and the INSPIRE framework[81] to reduce and prevent violence against children. These have collectively identified a range of strategies and programmes to prevent injury and violence, emphasising especially primary prevention interventions which aim to avert injury before it occurs.

Secondary prevention focuses on the immediate responses once an injury has occurred. This includes accessible and responsive emergency medical services to address physical trauma, and social services to investigate cases of child abuse and neglect and ensure and promote the safety of the

child. Health-care providers fulfil a critical role in secondary prevention – when children attend a health-care facility for an injury, critical questions should be asked about the context in which the injury occurred. Health-care providers can identify how children were injured and consider the risks for further injury or abuse and refer to appropriate support services, for example when a non-accidental injury is suspected or when a child shows signs of trauma due the injury.

Tertiary prevention focuses on rehabilitation and includes individual and family counselling, reconstruction and aftercare services as required by the Children's Act.[82]

Universal, selected and indicated interventions

Interventions may be directed at the general population or targeted at specific subsets of the population. For example, universal interventions include pedestrian safety campaigns directed at entire communities, and conflict resolution training for all high-school children.

Selected interventions target groups known to be specifically at risk of injury; for example, home visits for marginalised families with young children, or teen parenting programmes to reduce harsh parenting, promote attachment and encourage responsive and nurturing care.

Table 20: Injury prevention strategies and modifiable factors by ecological context

Injury priority	Ecological context	Selected modifiable factors	Intervention strategies and illustrations
Child abuse and youth violence	**Relationship**	• Conflict and domestic violence in the home • Alcohol and drug use • Poverty and food insecurity • Trauma •	• Parent and caregiver support (Parenting for Lifelong Health)[83] • Cash transfers combined with gender transformative interventions (Stepping Stones combined with Creating Futures)[84] • Evidence-based trauma-focused social support and counselling (Zambian Trauma-Focused Cognitive Behavioral Therapy Model using trained community-based lay counsellors)[85] • Youth participation project (Gun Free South Africa)[86]
	Community	• Alcohol and drug use • Social and cultural norms on gender • Safe environments including schools	• Walking Bus initiative (Centre for the Study of Violence and Reconciliation)[87] • Changing social norms (Raising Voices Uganda)[88] • Violence Prevention through Urban Upgrading (VPUU NPC)[89] • Education and life-skills programmes for in/out-of-school youth (PREPARE)[90] • Intimate partner violence prevention programme (Respect 4 U)[91] • Reduction of sexual violence against young girls in schools in South Africa (Centre for Justice and Crime Prevention)[92]
	Society	• Social and cultural norms on gender and violent masculinities • Weak enforcement of laws and policies	• Integrated Urban Upgrading Framework[93] • Lobbying for the promulgation of legislation to ban corporal punishment in the home[94] • Uganda National Strategic Plan to Prevent Violence Against Children[95]
Traffic injury	**Relationship**	• Poor supervision	• Adult pedestrian supervision (Walking Bus initiative)[96]
	Community	• Pedestrian infrastructure • Neighbourhood speed control • Protected play areas	• Education, reflective bag tags, and supervision of pedestrians from school (ChildSafe Walk this Way)[97] • School driver education, vehicle support and incentivisation (ChildSafe Safe Travel to School Project)[98]
	Society	• Driver norms and education	• Speed reduction strategies (World Report on Road Traffic Injury)[99]
Burns	**Relationship**	• Adult supervision	• Safe stove education (WHO Plan for Burn Prevention and Care)[100] • Caregiver support (Home Visitation Programmes)[101]
	Community	• Energy sources • Energy appliances	• Smoke detectors (Western Cape Disaster Management)[102] • Safe candle use (ChildSafe Safe Candle Project)[103]
	Society	• Paraffin appliance access and use • Excessive domestic water temperatures	• Paraffin stove regulation, substitution and enforcement (South African National Standards for paraffin stoves)[104] • Hot-water cylinder temperature regulation (21st Century Solutions for Child Safety)[105]

Case 10: Walking Bus initiative
Jemayne Andrews, Department of Community Safety, Western Cape

The Walking Bus project aims to improve learner safety on the way to and from school. Parents and volunteers from the community walk groups of children to and from school, providing safety and supervision in areas that are ridden by gang activity. The Walking Bus acts as a deterrent to would be perpetrators of criminal activities, and also helps prevent children from engaging in deviant behaviour. Some Walking Bus volunteers also monitor the perimeters of their local schools to ensure that they are kept clear and free from perpetrators. Others have been instrumental in ensuring that no drugs or weapons access the school grounds. Youth are searched and checked at the school gates, in the presence of law enforcement officers, as well as during the walk to school.[106]

Indicated interventions are aimed at groups who have already been exposed to injury, either as perpetrators or survivors. These interventions may include family strengthening to reduce conflict and domestic violence in the home. There is some evidence of the effectiveness of these interventions; however, many evaluations are restricted in their focus and evaluation of impact.

Established and promising programmes

In South Africa, and other similar low- and middle-income settings, there are a range of promising interventions, as outlined in Table 20. These may address individual, or multiple safety concerns (see examples in Case 10), the road environment (see Case 11), the community and home environment (Case 12),[107] the control of a key agent, e.g. firearms, which are associated with severe and lethal violence (Case 13)[108] or parenting programmes such as Parenting for Lifelong Health which aim to strengthen parenting and reduce child maltreatment (Case 14).

Despite South Africa's elevated levels of child injury mortality and morbidity, the country's prevention responses have in general been characterised by insufficient intersectoral collaboration; fragmentation; inadequate coordination; inappropriate resource allocation; and insufficient adoption of evidence in planning, implementing and monitoring interventions.[109] Furthermore, the extent of those interventions that are beneficial for more than one injury type has yet to be realised fully. These interventions include those directed at the key crosscutting risks for injury and violence, i.e. poverty, socio-economic inequality and inadequate community infrastructure; social norms focusing on gender inequality and patriarchy; and others. Such interventions may possibly also impact on other causes of childhood illness and mortality, e.g. the Department of Health's First 1,000 Days[110] and the Western Cape Department of Health's Side-by-Side campaign,[111] amongst others, that for example aim to promote safe, stable and nurturing relationships between children and their parents, and with multiple health and social benefits.

What are the implications of current knowledge for the policies and programmes that are in place?

In May 2011, South Africa endorsed the Sixty-Fourth World Health Assembly resolution on child injury prevention which entails prioritising the prevention of child injuries and implement multi-sectoral science-based policies and plans of action as recommended by the World Report on Child Injury Prevention.[112] The resolution built on the United Nations Convention on the Rights of the Child[113] which highlights public responsibility for ensuring children's rights to protection from all forms of violence and abuse. South Africa has since signed further supportive resolutions, notably the Sustainable Development Goals which include targets for reducing violence-related and road traffic deaths and injuries; the provision of inclusive, safe, resilient and sustainable cities

Case 11: Safe Travel to School Programme
Yolande Baker, ChildSafe South Africa

Minibuses provide a significant component of school transport in South Africa. This is especially true for children from working-class communities who reside far from schools. However, the industry is often criticised for using substandard vehicles, overloading and high-risk driving such as speeding. The Safe Travel to School Programme, implemented by Childsafe South Africa, focuses on road safety awareness, defensive driver training, eye-testing, roadworthy inspections, selected upgrades, incentives for safe performance, and the implementation of a vehicle tracking system with regular, individual driving behaviour information updates. Despite concerns that some school transport vehicles are used for multiple purposes outside of school, at night and for longer distances, drivers on the programme recorded less speeding, harsh braking, and harsh cornering and acceleration than general drivers.[114]

Case 12: Creating Safer Communities through Urban Upgrading
Fathima Rawaat, Violence Prevention through Urban Upgrading

Violence Prevention through Urban Upgrading (VPUU) works with local communities to co-create safe public spaces and neighbourhood resource centres called "Active Boxes". These multifunctional community buildings are strategically placed along a major pedestrian route and adjacent to a public square, park or sports field. Community members are actively involved in deciding on the location, design and function of the Active Boxes and the spaces are then activated through partnerships with residents, non-governmental organisations (NGOs) and local government in order to provide a range of services, recreational and economic opportunities.

For example, the Safe Hub at Nyanga Junction is located outside a busy train station at the intersection of Guguletu and Mannenberg (two of the most violent areas in Cape Town). It includes an AstroTurf operated by Amandla Football and provides a positive alternative to gangsterism and violence. Similarly, the Active Box in Monwabisi Park incorporates an ECD resource centre, community hall, open-air classroom, community information office, caretaker's flat, public toilets, kitchen, and offices for local government, NGOs and local leadership.

The ECD resource centres include a toy library and provide teacher training and an outreach programme to unlock the potential of young children. Training local women as ECD teachers helps make the project more sustainable and easier to scale and is aligned to an asset-based model of development.

and human settlements with access to safe, affordable, accessible and sustainable educational, mental health and transport systems for all; and special considerations for those in vulnerable situations, including women, children, persons with disabilities and older persons.[115] More specific global instruments, such as the United Nations Decade of Action for Road Safety,[116] emphasise safer road environments, safer vehicles, safer road users and efficient post-crash response systems.

These global commitments to child health and safety are echoed in the South African Constitution and Bill of Rights, and given effect through a range of laws, policies, regulations and standards. Some of these specifically focus on violence and injury prevention and child protection, while others address the upstream crosscutting determinants by strengthening the rights of all South Africa's, including the rights to life, dignity, equality, social assistance, housing, and an environment that is not harmful to health. These include:

- the Children's Act,[117] Child Justice Act,[118] and the Sexual Offences Act[119] which collectively enhance the child's protection from violence and abuse;
- the National Road Traffic Amendment Act[120] and National Road Safety Strategy 2016 – 2030 which focus on road safety;
- the South African National Standards for non-pressurised and pressurised paraffin stoves which focus on environmental and energy safety in the home;[121]
- the Notice of Destruction of Firearms[122] under the Firearms Control Act[123] which focuses on firearm reduction;

Case 13: South African teenagers using radio to fight gun crime
Sara Chitambo, Gun Free South Africa

For the past two years, Gun Free South Africa has been working in partnership with the Children's Radio Foundation. Youth reporters draw on a community safety toolkit to raise awareness and empower other youth to act against gun violence through Alex FM radio, social media and outreach events at schools. This has led to greater civic engagement and youth-led advocacy calling on local leaders, police and businesses to build safer communities, including creating gun-free zones in primary schools in Alexandra.

Through the programme, more young people have become aware of the risks of gun violence in their communities and their own power to help create safer communities and to take action, for example, by petitioning the police to remove illegal guns. In the process, strong operational networks have been built between the reporters, youth-focused community-based organisations, learners and educators at primary and high schools, community radio stations, and local community stakeholders – all committed to promoting safer communities.

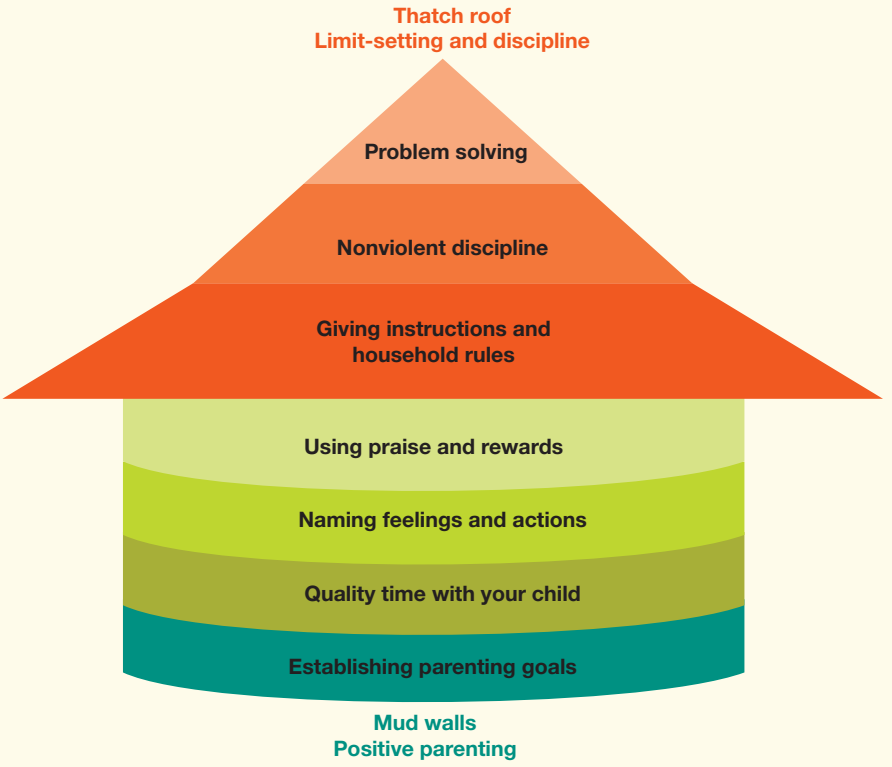
- the Prevention of and Treatment for Substance Abuse Act[124] and the Control of Alcohol Marketing Bill which both focus on control of alcohol, and

Case 14: Parenting for Lifelong Health

Catherine Ward, Department of Psychology, University of Cape Town

Parenting for Lifelong Health for Young Children[125] known as Sinovuyo Kids in South Africa, is the first parenting programme for parents of 2 – 9-year-olds that has been developed and rigorously tested in Africa. This programme was developed in response to the need for an effective and low-cost intervention to strengthen parenting and reduce child maltreatment. The programme is based on social learning theory and was designed by a team of researchers together with parents in South Africa and colleagues at the World Health Organization, UNICEF and local NGOs. It is delivered by trained and supervised facilitators (often lay community members) to groups of caregivers over 12 weekly sessions. Sessions focus on building a strong parent–child relationship and equipping parents with positive discipline strategies – the programme uses the analogy of a "rondavel of support" for this: helping parents first build strong walls (i.e. a loving and warm relationship) before constructing a roof (i.e., manage difficult behaviour positively). A study of the programme with 296 parents in Nyanga and Khayelitsha showed promising results. Parents who participated in the programme said that they used positive parenting more often and used less physical and emotional punishment than those who had not. They also had more positive interactions with their children, who behaved better, during the structured play task. One year later, the participating parents still reported using more non-violent discipline strategies. For other factors, there was no difference, though, such as the behaviour of children as reported by their caregivers, the level of poor monitoring or supervision, and caregiver social support. The study showed that evidence-based parenting programmes, like Sinovuyo Kids, are feasible in South Africa and can contribute to family strengthening in the country.

Figure 37: Rondawel of support



- a recent 2019 ruling by the Constitutional Court which has declared the common law defence of "reasonable chastisement" unconstitutional. The Court found that a child has the right to be free from all forms of violence in the home and should not be subject to corporal punishment (see case 15).

However, the full extent to which factors such as poverty, socio-economic inequality and inadequate community infrastructure; gender inequality and dominant masculinity norms; alcohol and drug abuse; access to firearms; the lack of a culture of law enforcement and safety; and the intergenerational cycle of violence are addressed by the current policy and legislative frameworks requires a critical reflection of the latter's contributions, strengths and limitations.

What is needed to promote a coordinated national child safety agenda?

While South Africa has adopted various laws, policies and programmes in line with international instruments to prevent child violence and injury, the country's response has been fragmented by a lack of coordination and stewardship at the highest level. At the same time, existing research on child violence and injury is limited in scale, and located within disciplinary and institutional silos, thereby reducing its influence on policy, financing and intervention decisions.

Countries that have seen the greatest gains in violence and injury prevention have invested in injury and violence prevention implementation research.[126] Implementation research requires funding and knowledge of implementation

Case 15: Corporal punishment in the home "unconstitutional"

Lucy Jamieson, Children's Institute, University of Cape Town

Corporal, or physical, punishment is any punishment in which "physical force is used and intended to cause some degree of pain or discomfort, however light".[127]

It involves, but is not limited to, hitting (smacking, slapping, spanking) children in any environment or context, including the home setting, with the hand or instruments such as a whip, stick, belt, shoe or wooden spoon. It can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, caning, forcing children to stay in uncomfortable positions, burning, scalding, or forced ingestion.

On 18 September 2019, Chief Justice Mogoeng Mogoeng announced the Constitutional Court's decision on corporal punishment in the home.[128] In a unanimous judgment, the court declared the common law defence of "reasonable and moderate chastisement" invalid and unconstitutional. This means that the law no longer protects parents who use force, even a light smack, or the threat of force to discipline a child. In addition to the legal arguments made during the hearing, the Children's Institute and other experts submitted evidence showing that corporal punishment is inherently degrading, ineffective,[129] can lead to more severe forms of abuse,[130] has negative long-term effects on individuals, and stimulates an intergenerational cycle of violence[131].

Building the capacity of parents to use positive, non-violent discipline improves the quality of the parent–child relationship and can reduce other forms of violence including intimate partner violence.[132] The court concluded that corporal punishment is a violation of the best interest principle and children's rights to dignity, equality and freedom from violence, and because parents can use positive discipline to raise their children, it is not justifiable to hit children.[133]

Recognising that it is not in the best interest of children for parents to be criminalised for something that has been common practice, the Court called on Parliament to consult with parents, children and other interested parties on a regulatory framework that would outline how the state and child protection agencies should deal with reports. According to the legal principle *de minimis non curat lex*, the law does not concern itself with excusable and/or trivial conduct, hence, prosecutors have discretion on whether or not to prosecute cases of assault. But there needs to be a clear set of principles based on restorative justice that determines how cases should be handled, including the option to refer parents to community-based parenting programmes.

The law should place a clear obligation on the state to promote change. The use of corporal punishment is still widespread and will require significant investment to shift attitudes and change behaviours of parents, professionals, community leaders and children. The Children's Amendment Bill submitted to Parliament presents an opportunity to create awareness, and to develop programmes to support parents to learn positive discipline so that we end the use of corporal punishment.

science to identify what is required to support the implementation and scale-up of programmes to address the complex multi-dimensional nature of violence and injuries.[134] There is still limited support for evidence-led solutions with increasing – but still relatively limited – research and intervention funding. While child violence and injury prevention solutions do exist, more investment is required.

A massive shift is therefore needed to deliver interventions and services to communities at scale. This is contingent on government identifying child safety as a strategic priority, fostering partnerships between government and non-governmental organisations, supporting the evaluation of programmes to determine "what works" to prevent injury and violence in the South African context, and developing an intersectoral prevention plan guided by the following broad principles:

- *Effective leadership* is needed at all levels of government and civil society to ensure that safety risks to children are understood and addressed. This includes the coordination and implementation of appropriate priority intervention strategies. Leadership needs to be institutionalised nationally, with the requisite authority and resources to mobilise an intersectoral response that upholds children's rights through the delivery of health, housing, energy, education, transport and social services. Such leadership needs to support intersectoral collaboration across the various violence and injury prevention disciplines and sectors. A structure, such as an office in the Presidency, may be well placed to coordinate and mobilise a national child violence and injury prevention strategy.
- *Intersectoral collaboration* is essential to support the design and implementation of a national strategy and the comprehensive programmes required to address the common, crosscutting and injury-specific risk factors at different levels of the socio-ecological system. There is a need to identify the role of each of the state departments and non-governmental agencies that have a mandate for child violence and injury prevention. The implementation of interventions on crosscutting and key drivers of child violence and injury should be a priority across the programmes in the Social Protection, Community and Human Development cluster which already include a focus on (i) early childhood development, (ii) challenges of housing and human settlements, (iii) poverty alleviation, and (iv) building cohesive and sustainable communities,[135] and with selected crosscutting child safety factors also prioritised by a number of non-governmental agencies[136].
- *Strengthened surveillance and information systems* are required to monitor patterns of childhood injury and violence – besides mortality, to ensure that prevention and treatment programmes respond timeously to emerging trends. There is a need for a national child safety surveillance system that includes monitoring hospital admissions at sentinel sites to guide priority setting and resource allocations, and monitor the impact of interventions.
- *Evidence-based early prevention interventions across a life course approach* is recommended to respond to the complex and multi-dimensional nature of violence and unintentional forms of injury. Interventions should be evidence led and research should honour both scientific and community-embedded knowledge to ensure the development of locally relevant and context-situated prevention programmes. Monitoring and evaluation need to be built into programme design and lessons learnt should be disseminated to support the wider uptake of good practices and scaling up of interventions. Interventions aimed at prevention also need to be costed as this can guide what is practically feasible and sustainable and alert policymakers to the cost of not investing in prevention.

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