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## **Child Maltreatment Prevention Readiness Assessment: South Africa**

**Report submitted to the World Health Organisation Department of  
Violence and Injury Prevention and Disability, Geneva**

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# 1. Background

## 1.1 Country Profile

South Africa has an estimated population of close to 50 million people. In 2009 it was estimated that of the 49.4 million people, 18.6 million (38%) of the population were children aged less than 18 years (Children's Institute, 2011). About 15,504,200 of the population are children aged 0-14 years (Statistics South Africa, 2010). The gender distribution is 51% boys and 49% girls. The current cohort of 0 to 18 year olds also known as "Mandela's Children" (Barbarin & Richter, 2001) are the first generation to experience a childhood in a non-racial society that is safeguarded by international and domestic human rights laws. Their survival, protection and development are guaranteed under these legal instruments and after the transition into democratic rule various institutions were created to ensure pursuance of these goals.

South Africa is a developing middle-income country characterised by high wealth and income inequalities, unemployment, poverty and high HIV/AIDS prevalence which negatively affect child wellbeing. Based on household survey data obtained from the government statistical agency (Statistics South Africa) the World Bank estimates that South Africa, with a Gini coefficient of 0.68, is one of the most unequal societies in the world. A large proportion of South Africa's population (26.2%) continues to live in poverty when the poverty line of US\$ 1.25 per day is used (United Nations Development Programme, 2010). The unemployment rate is estimated at 24%. In 2009 about 36% of children lived in households with no employed adult (Children's Institute, 2011). It is estimated that more than 12% of children aged between 2 and 18 years are single or double orphans with almost half of the parental deaths attributed to AIDS-related illnesses (Martin, 2010). A combination of these factors in children's lives negatively affect their care and wellbeing, and may expose them to harm.

There are policy efforts to promote the general development and wellbeing of children through health, education and social development programmes provided to communities and families, with services to help members develop their potential. Martin (2010) provides a comprehensive documentation of programmes and services for vulnerable children provided by government departments, in the areas of health, child development and education. The Department of Health provides free health services for pregnant and lactating women, the under-6s, children whose parents have moderate to severe disabilities, 6 to 18 year olds if they depend on social assistance grants for income; subsidized health care if parents have no income other than social grants; free primary health care for children aged 6 to 18 years. Other programmes focus on nutrition, HIV/AIDS care and treatment, immunization, and school health services which will be introduced in some areas and expanded in others through the implementation of the National Health Insurance (NHI) policy.

The Department of Social Development provides subsidized early childhood development (ECD) services for younger children (0 to 4 years old) in community-based facilities while the Department of Education subsidizes school-based ECD services focusing on children in Grade R (5 to 6 years old). Provision of ECD services is guided by the developmental approach and focuses on emotional, social, physical, cognitive, sensory, moral, spiritual, communication development of the child. Beneficiaries are children from birth until school going age (6 years). Priorities include the important aspects of the early childhood phase of life such as nutrition, child care, health care, environmental safety and early education and learning. The services include interventions for children, parents and primary caregivers. A policy framework for orphans and other children made vulnerable by HIV and AIDS (Department of Social

Development, 2006) includes provision for integrated early childhood services for this category of children.

Despite this attention to service-oriented policy, a number of challenges remain, including the high number of youngest children (0 to 4 years) who do not have access to early childhood development services. A study of ECD services in the Western Cape Province found that service integration for younger children was consistently poor while identification and referral of children with problems were seldom done at community level. Furthermore, ECD site management did not engage proactively with families of children who have problems and provide support or encourage attendance of ECD facilities (Dawes, Biersteker & Hendricks, 2009). Early childhood phase is critical in determining the development of a child but in poor resource contexts children's ability to realize their potential is undermined by risk factors in early life including low stimulation and poor nutrition (Walker et al, 2007). A study of children's court inquiries in the Western Cape province indicated the potential role of ECD-linked child care to reduction of child maltreatment of children aged 0 to 4 years who were affected by statutory removals (Makoae, Dawes, Loffell & Ward, 2008).

There is a high prevalence of youth who bear children in their adolescence. The adolescent fertility rate (births per 1000 women aged 15-19) is estimated at 58 births per year (World Data Bank, 2008). What makes child bearing among teenagers in South Africa a social concern is that it mostly occurs outside marriage; disrupts schooling, does not lead to marriage and contributes to the widespread situation of 'absent fathers' during a child's upbringing. Children born to young mothers grow up with fewer opportunities for development provided by families than with present fathers. Furthermore, maternal poverty, due to low educational attainment and consequent poor incomes, contributes to stressful parenting among young single mothers (Panday et al, 2009). Maternal education deficit has been associated with negative child welfare, education and health outcomes (Ardington et al, 2011). A study using the Cape Area Panel Study data, waves 1 to 4 of this longitudinal study of young people in Cape Town since 2002, found that teenage child bearing had poor health outcomes for children – an intergenerational effect of poor health as indicated by children who were underweight, shorter than their age and stunted (Branson, Ardington & Murray, 2011).

Despite the commitment by the democratic state through its institutions and partnerships with its national and international development partners to promote equal opportunities and the well-being of all children, childhood in South Africa continues to be affected by several threats and vulnerabilities, a number of which are directly and indirectly due to violence. For instance, children may be directly affected if caregivers use corporal punishment; they may be indirectly affected if their caregivers die in violent incidents.

## **1.2 Brief overview of child maltreatment prevention and child protection in South Africa**

South Africa has ratified the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. Domestic legislation and policies that promote the survival and wellbeing of children have been developed with the socioeconomic rights of children high on public agenda. However, ill-treatment and violence against children, including child maltreatment are serious problems that threaten the rights of children to survival, health, development and protection. Child maltreatment is defined as: "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or

other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (Krug et al, 2002).

Child maltreatment can occur in many different settings. The perpetrators of child maltreatment may be:

- parents and other family members;
- caregivers;
- friends;
- acquaintances;
- strangers;
- others in authority – such as teachers, soldiers, police officers and clergy;
- employers;
- health care workers; and
- other children.

In South Africa child neglect was recognised as a social problem from the turn of the 20<sup>th</sup> century with the Children's Protection Act passed in 1913 and case reports of child maltreatment published as early as 1981 even though provision of child protection services was based on racial exclusion (Gannon & Hoffmann, 1996). Moreover, child protection systems primarily consisted of state services mandated to receive and respond to reports of child abuse and neglect, thus it placed emphasis, in terms of resources, on children who had already been found to be affected by maltreatment, investigated the incidents and placed the children in alternative care (Waldfoegel, 2009). Following democratisation in 1994, there has been a policy reform in relation to child and family services. The White Paper for Social Development (South Africa, 1997) emphasised primary prevention and early interventions programmes for more coverage and sustainability. In practice, however, child welfare and protection services have continued to be predominantly delivered at the tertiary level and narrowly focused on the child. The services and resources are concentrated in responding to reported cases of child abuse and neglect and are mostly oriented towards removing children in need of care from high risk families into alternative care in the form of foster care and institutions.

The Children's Act, Section 110, mandates "Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who on reasonable grounds concludes that a child has been abuse in a manner causing physical injury, sexually abuse or deliberately neglected", to report such incidents. Professionals are obliged to report child abuse and neglect, using the "Form 23", to a designated child protection organisation, the provincial Department of Social Development or a police official. Following investigation by a social worker, cases of children found to be in need of care and protection are recorded with all identifying information into the child protection register maintained by the national Department of Social Development. The social worker conducts investigations and makes recommendations on the services that a child and the family need (non-statutory or statutory); and if immediate harm is identified, the social worker will request the police to remove the perpetrator from the child's house or the child may be removed into a safe place. Assisted by government subsidies, non-governmental organisations play a crucial role in the provision of services including protection for children. The Child Protection Register is kept and maintained in terms of Section 111 of the Children's Act and consists of two



parts, A and B. Part A records all the reports of abuse or deliberate neglect of children. The purpose of maintaining the register is to determine trends, patterns and prevalence rates according to communities to inform prevention programmes. Part B of the register documents people who have been found to be unfit to work with children following child protection investigation that found them to be perpetrators of child maltreatment.

Mandatory reporting as an integral element of child protection is intended to prevent repeat maltreatment, further harm and possible homicides. However, both assessment and screening of children, parents and families, including pregnant women, for child maltreatment risk are not institutionalized making it difficult to identify risk factors and apply the ecological framework for the primary prevention of child maltreatment.

Although there is a controversy, the country has not made a shift that was envisaged in the White Paper yet, when it comes to programmes that support families to provide care for children. The White Paper provided a comprehensive policy framework, and advocated for a shift away from clinical and individualized approaches to welfare services that would adopt community development approaches to the problems affecting families and children. Such approaches would address the majority of citizens, socioeconomic contexts within which social problems occurred and be rights-based (Matthias & Zaal, 2008). The Paper emphasised the adoption of developmental social welfare policies and programmes, and thus introduced a new way of thinking about providing social welfare. However, one of its weaknesses was failure to specify the features of the envisaged programmes to bring about the desired changes. As a result, debates about the operationalisation of developmental social services and social development did not transform service delivery (Gray & Lombard 2008).

Implementation and financing of programmes continue to overlook prevention. Preventive interventions are in the form of child care, support, and treatment of children and affected families through early intervention (intervention before statutory removal is necessary) and tertiary intervention (intervention that may be based on a court order when serious problems have been identified and the statutory processes invoked; that is, these mainly comprise interventions that respond to child maltreatment after it has occurred). One important consequence of this approach to child protection is that many children enter the formal statutory care system as a means of ensuring their protection and care, thus depriving them of the family environment for care and upbringing. The concern is that with inadequate human resources (especially professional social workers) to monitor services for children in statutory care, there is a risk that the norms and standards are not always adhered to, thus placing children at risk even in their new, supposedly safer environment, of their physical, developmental and cognitive needs not being met (Makoe, Ward & Dawes, 2009). While noting the limitations of the national adoption register as a source of data on children in need of care, analysis of adoption patterns shows that members of South African society are not generally likely to adopt children including those formally placed in their foster care (Mokomane et al, 2011). As a result institutional and foster care remain common practices.

The Paper acknowledged the weaknesses of the family introduced and sustained by a long history of oppression and inequalities, but did not lead to institutionalization of a coherent family policy and parenting programmes. Implementation of programmes has predominantly focused, on reducing child poverty through social assistance programmes, especially the child support grant. The child-headed household grant, foster child grant, and care dependency grant also form part of monthly social assistance transfers paid to poor families with vulnerable children. By April 2011 about 10.5 million children aged from 0-16 years received the child support grant valued at R260 per month; 522 000 children received the foster child grant valued at R710 per

month; and 113 000 children aged between 1 and 18 years received the care dependency grant for children with severe disabilities who require permanent care valued at R1140 per month (Children's Institute, 2011). Caregivers of the beneficiaries have the responsibility to ensure that the beneficiaries remain in school.

While these may well reduce child maltreatment through reducing stress on households, they are not directly child maltreatment prevention interventions. This approach was absolutely necessary given the income inequalities and widespread household poverty, but there has been a lack of social investment in programmes that improve parental care-giving competencies, home visits increasing parental knowledge of child development, and encouraging positive child management strategies. Preventing child maltreatment in home settings is currently weak. Sometimes the need to support parents to cope with their parenting roles is easily misinterpreted to entail social assistance in the form of cash transfers. Parenting education programmes to enhance the development and wellbeing of children has been a neglected area.

Additionally, South Africa is a culturally and ethnically diverse society. Different cultural groups have different norms and values regarding childhood and discipline but there may also be intra-cultural variability due to varied socio-economic status, place of residence, own children's agency and understanding of parent-child interaction. The principle of non-discriminatory social services in South Africa emphasises dignity, tolerance and respect for clients in the process of providing services. However, there has not been evidence that child protection programmes and services take into account the cultural diversity of the members of the communities they provide with services. This is illustrated by a lack of scientific studies on childhood in general, child care, interaction and perceptions about child protection services and child maltreatment prevention that are based on culturally defined communities and neighbourhoods in South Africa. Korbin (2002) states that studying small scale social systems such as neighbourhoods provides meaningful contexts for rates of child maltreatment yet "there are many missed opportunities to understand how the experience of culture is related to child maltreatment" (Korbin, 2002: p.642) including its utility for prevention of and response to child maltreatment.

The Children's Act (Act 38 of 2005 as amended) is, among others, intended to rectify the historical bias towards provision of child protection services. Chapter Eight in the Act is dedicated to Prevention and Early Intervention programmes. The services include the following: family preservation services; parenting skills programmes/counselling; parenting skills programmes/counselling and support for groups for parents with children with disabilities and chronic illnesses; parenting skills programmes/counselling to teach parents positive, non-violent forms of discipline; psychological, rehabilitation and therapeutic programmes for children affected by abuse, neglect, trauma, grief, loss or have behaviour and substance abuse problems; and programmes aimed at strengthening/supporting families to prevent children from being removed into statutory care.

Chapter 8 further outlines responsibilities across the different spheres of government but more specifically requires Provincial Departments of Social Development to fund prevention services. This has led to a universal review of provincial child care and protection plans to include prevention interventions envisaged in the new law. The Act also obliges various government departments: Departments of Health, Education, Justice and Constitutional Affairs to collaborate with the Department of Social Development in the implementation of the Act.

Furthermore, intersectoral planning of programmes and referrals to effective preventive services remain weak and although there is a desire to coordinate health and social welfare services,

there is currently no evidence in both policy and practice of the two sectors collaborating to prevent child maltreatment. For example, the problem of HIV and AIDS has highlighted the need to provide care for children whose parents and caregivers are physically ill, but the extent to which health care and welfare agencies make child protection referrals based on clinical assessments is unknown. Additionally, the link between maternal mental ill-health and child maltreatment has not yet received adequate attention in policy and services. This gap exists despite research showing that maternal depression is a common phenomenon among ante natal and postnatal services users with a prevalence of 34.7% reported in low-income communities in South Africa (Cooper, Tomlinson, Swartz et al, 1999). It is probable that mental illness is under-diagnosed and there is a lack of programmes that help to prevent mothers who have mental problems from harming their children. Severe maternal mental health problems also negatively affect the interaction of mothers with infants and is a risk factor for mother responsiveness to the child's needs (Walker, Wachs, Gardner et al, 2007). Even though the country has guidelines for reporting and responding to abused children, children at risk and in need of care exist, the circumstances of such children may be perceived differently. The health sector (for instance) is of course an important one for recognizing and responding to cases of child maltreatment, but at present there is no evidence as to their success at doing so.

Thus the major weaknesses of the national measures to address the needs of children vulnerable to child maltreatment are three-fold. Firstly, in an effort to be child-centred, their implementation lost focus on the import of the ecological framework and did not ensure that parent and caregiver factors that place children at risk other than poverty were systematically addressed. The advantages of providing family focused services that include caregivers when addressing service needs for children living in poverty and in need of care has been repeatedly demonstrated (Richter et al, 2009). Secondly, policy interventions are focused on poverty alleviation yet it is not the only risk factor for poor child wellbeing outcomes; thirdly cultural diversity has been largely ignored, and fourthly, there is a lack of coordination of services provided by different departments, especially the Departments of Health and Education.

As is the case internationally, policy agendas and initiatives to improve child protection do not include a systematic collection of data on children affected by the different forms of abuse and neglect. Data unavailability is a problem that may be attributed to variations in the definitions and usage of related terms such as child protection. UNICEF provides reporting on child protection focusing on birth registration, child marriage, child labour, female genital mutilation/cutting, attitudes towards domestic violence, child discipline and child disability (UNICEF, 2009)<sup>1</sup>. Gaps in country-level child maltreatment data limit advocacy on the implementation of prevention interventions. Effective prevention programmes require an evidence base regarding the extent of child abuse and neglect, its distribution among local communities and the risk factors prevalent in the areas and among individual families (caregivers and children). Efforts to address the risk factors require a systematic approach to gathering data on context-specific child protection issues and are dependent on multi-sectoral approaches. Since the child protection register system has not been effectively implemented the country does not have a reliable child maltreatment surveillance data. Small-scale research supported by the government of South Africa has indicated that in the Western Cape Province child abuse and neglect that lead to statutory intervention is common (Dawes et al, 2006; Makoae et al, 2008). Several risk factors for child abuse and neglect have been identified as follows:

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<sup>1</sup> UNICEF (2009) State of the World Children, Celebrating 20 years of the Convention on the Rights of the Child. United Nations Children's Fund, New York.

- substance abuse by caregivers (including during pregnancy),
- unemployment,
- exposure to intimate partner violence,
- poor child supervision due to lack of access to child care and economic migration,
- inadequate housing,
- teenage childbearing, and
- presence of a non-biological parent male adults in households with children.

Of course, these do not determine child maltreatment; these socio-economic and behavioural factors merely indicate increased likelihood that it will occur (primarily through stress on caregivers).

Provision of prevention services to address child maltreatment is vital given the wider societal benefits of prevention. For example, an aftercare programme at a school will reduce the risk of young children being maltreated after school when there is no suitable person to supervise them at home. Facility-based parenting skills and early childhood development programmes discuss various topics that help parents and children with skills that protect children from harsh discipline, neglect and abuse. The field of child maltreatment prevention has been expected to develop in earnest following the enactment of an enabling legal instrument – the Children’s Act (No. 38 of 2005 as amended). According to the Act, prevention programmes are needed to strengthen and support families with children to address problems that could or will eventually occur in the family environment (and if those problems are not dealt with it could lead to statutory intervention like the removal of the child from the family).

The shortage of human resources in the social care sector is a chronic problem. It has been argued that government’s overemphasis on training community development workers, and criticism of social work services that were funded by the apartheid government, were viewed as contributing to the lack of social workers in the country (Gray & Lombards, 2008). The criticism and perceived decline in funding for private non-governmental organisations that had a long history of providing social welfare including child protection encouraged migration of social workers and discouraged new entrants to follow social work as a profession (Gray & Lombards, 2008). There is still a bias towards resourcing of interventions that respond to reported child maltreatment with statutory care and child maltreatment prevention programmes are minimal, weak and poorly supported with professional skills. Expansion of services to the majority of the population who were previously excluded exacerbated the human resources problem. This situation has partly been improved by implementing the training of various occupational groups stated in the White Paper in addition to social workers: child and youth care workers, community development workers and probation workers (Gray & Lombard, 2008). The predominant approach to child protection in the country, one that is focused on mandatory reporting, investigation and intervention could be seen as a symptom of inadequate human resources, There are not enough social workers who can conduct needs assessments, follow-up on families and implement effective referrals to other services, maybe besides health care.

### **1.2.1 Recent and on-going developments**

Some shift in practice, though with a limited focus on specific children, has been noticed with the emergence of orphaned and vulnerable children – primarily those who are affected or infected by HIV and AIDS – as a distinct category of children in need of care. Increasingly, these children’s needs for care and protection are being addressed with the view of preventing child abuse and neglect in a coherent manner. Several models of home visitation services have been

implemented by NGOs to vulnerable and orphaned children and their families in the context of HIV and AIDS. The systematic and proactive manner in which communities respond to risk factors that affect children affected by parental chronic illness or death and trigger formal child protection systems is commendable. Children who are similarly at risk of child abuse, neglect, exploitation and child labour, as a result of different family situations would benefit from services that support vulnerable families in similar ways. For example, in previously disenfranchised communities inadequate housing, teenage childbearing and lack of child care services, high levels of family disorganization, substance abuse and poverty are common risk factors for child maltreatment. Addressing the needs of children to ensure that they receive services before an incident happens rather than following reports of child maltreatment to child protection authorities, in the form of early intervention (secondary prevention) or statutory care should be a priority for child protection in South Africa.

South Africa is in the process of implementing a national child maltreatment and victimisation surveillance system. The Department of Social Development in collaboration with the Child Welfare League of Canada (CWLC) have embarked on the Child Protection Surveillance project with funding from the Canadian International Development Agency. The study will enhance the capacity of the Department of Social Development and civil society partners in the provision of child protection services across the country. It will provide the framework for the development of a national surveillance system on child abuse, neglect and exploitation that can be implemented countrywide. The initiative will improve the availability of accurate data on the magnitude of child maltreatment in the country thus facilitating planning and prioritisation of services.

The most recent development in the child protection sector services entails the re-instating of the Family Violence, Child Protection and Sexual Offences Unit within the South African Police Services after the unit was disbanded five years ago. In the 2013/2014 State of the Nation Address, President Jacob Zuma remarked on the escalating violence committed against women and children in the country. He pointed out that Sexual Offence Courts will be established to complement the sexual offence units. This is likely to improve services for children when they come into contact with the police through a report of child maltreatment, both in terms of speed and quality of service.

### **1.2.2 Roles and responsibilities**

Both the White Paper for Social Welfare and the Children's Act stipulate the need for collaborations between government departments in providing welfare services for disadvantaged families and children. The Department of Social Development is the lead organisation. The National Department's role is to formulate policy framework, provide funding for provincial departments and account to parliament. Provincial Departments of Social Development implement policies by developing specific strategies given local contexts, implementing programmes and coordinating provincial actions. The Children's Act obliges the provincial departments of Social Development Ministers to fund and implement services contemplated in the Children's Act. Since the Act specifically obligates the Department of Social Development to implement prevention programmes, one of the yardsticks to assess commitment of provincial governments to preventing child maltreatment would be by analysing budgets for CMP components. Budlender & Proudlock (2011) have concluded that budgetary allocations for child care and protection, and family care and support programmes in the provinces are either stagnant or have been slightly reduced. Since child maltreatment

prevention interventions would be subsumed under these programmes, there is a reason to be concerned that funds for these programmes are not sufficient.

In addition, the Children's Act has identified designated child protection organisations (non-governmental organisations) providing child protection services as government partners in service delivery. NGOs are mandated and funded by provincial Departments of Social Development to implement various programmes for child protection. Giese and Sanders (2008) identify Child Care and Protection Forums at national level and Child Protection Committees at provincial level as responsible for monitoring progress on the implementation of child protection services. These Fora and Committees draw their membership from government departments of Labour, Health, Education, Correctional Services, Home Affairs, Foreign Affairs and South African Police Service (SAPS) and Civil Society representatives.

Inter-sectoral approaches are considered critical for enhancing comprehensive service provision for children and their families. Both the White Paper for Social Welfare and the Children's Act point to the need for state-private sector partnerships in the provision of welfare services including services for children in need of care and protection. The rights-based approach and the "follow the child" principle are emphasised in social welfare services for vulnerable children following recommendations by the report of the Lund Committee on Child and Family Support (1996). Although both White Paper for Social Welfare and the Children's Act recognise the vulnerability of families as a result of unjust policies of the past, policy discourse highlights that government's explicit intentions to support families with children using the "follow the child" principle is weak on supporting families as units. This approach is justified by the developmental welfare state approach adopted by the democratic government, a measure which was intended to prevent dependency on social welfare.

The major problem with the developmental welfare state approach is what seems to be a narrow operationalisation of benefits to families. The Lund Committee was critical of the excessively abused system of state financial transfers through the State Maintenance Grant (SMG) to single mothers and their children and instead recommended the Child Support Grant (CSG). With the risk of over-simplification, in South Africa social welfare, at least in practice, are almost exclusively in the form of cash transfers. This has led to non-cash services that could be used to strengthen vulnerable families and parents being overlooked. The visible lack of a coherent strategy to provide child maltreatment prevention services for parents and caregivers can be understood in this context. Early childhood development (ECD) programmes could provide parents and caregivers with advice and respite from care while also stimulating children, and such approach would integrate child maltreatment prevention in ECD without financial transfers to parents.

### **1.3 Rationale for a child maltreatment prevention readiness study in South Africa, ethical considerations**

South Africa has high levels of violence against children (Seedat et al, 2009). This is despite the existing legal and policy framework that are rights-based. In 2009 the Human Sciences Research Council conducted a qualitative study to determine South Africa's state of readiness to prevent child maltreatment. This study found that among others, the level of child

maltreatment prevention readiness as measured by policy makers' and implementers' knowledge about child maltreatment prevention, resource availability and programme implementation, was low (Makoae et al, 2009).

The current study was part of a multi-site cross-sectional study implemented in six low-and-middle income countries (LMIC) – Brazil, China, Macedonia, Malaysia, Saudi Arabia and South Africa. The assessment of country readiness was done against the backdrop that while evidence-based child maltreatment prevention interventions are necessary for reducing harm, injury, exploitation and inadequate care for children, they are not sufficient for ensuring successful implementation of preventive measures. Also critical is the larger environment consisting of legislation, institutions and policies; knowledge and perceptions of various role players about child maltreatment and its prevention; capacity in terms of human and financial resources and the landscape of programmes implemented with the aim of preventing child maltreatment in a country. The assumption is that a country's score on these aspects of readiness will influence decisions about how to approach the introduction or scaling-up of evidence-based child maltreatment prevention interventions.

“Readiness“ was defined as the extent to which:

- key players' attitudes are supportive of child maltreatment prevention;
- there is will in society to address the problem is present;
- the necessary resources in terms of personnel, infrastructure, and funding are available;
- adequate legislation and policies for preventing child maltreatment prevention are in place.

Finally, the ethical import of prevention undoubtedly obliges governments and other role players to ensure that they prevent child maltreatment before it occurs by eliminating or reducing the likelihood of harmful behaviour affecting children. This approach requires that a distinction between child protection and child maltreatment prevention is drawn. Waldfoegel (2009) indicates that prevention measures should ideally be able to prevent future maltreatment by addressing the risk factors for maltreatment “before they escalate into full-blown abuse or neglect, saving children needless suffering while also saving [child protection services] and other agencies the costs that would be entailed by a subsequent report, investigation, and on-going service delivery” (Waldfoegel, 2009: 206). In South Africa this distinction does not necessarily match the way these terms were used, but as used by WHO, the basic difference between these two terms is that:

- *child protection refers to measures taken **after** child maltreatment has occurred – such as support, care, and treatment of the traumatized child.*

- *child maltreatment prevention refers to measures taken to prevent child maltreatment **before** it occurs by addressing the underlying causes and risk and protective factors – such as teaching positive parenting skills to pregnant first-time mothers.*

The value of prevention is that in the long run, it will alleviate the challenge of the need by the state to intervene in family life and remove children from parental care.

While early intervention and tertiary interventions are necessary, they tend to be resource intensive and in low resource contexts, they may compete with child care and development services. Additionally, in the context of South Africa, children are likely to be placed on programmes that have not been evaluated or whose effectiveness is unknown as many programmes have yet to be evaluated.

Although South Africa has developed an elaborate child protection system consisting of strategies and systems for responding to children in need of care, recent acute shortages of human resources to monitor the development and trajectories of children in statutory care raises questions about the consequences of statutory intervention. A growing number of studies on child maltreatment have examined the consequences of child abuse and child neglect focusing on health risk behaviours and long-term chronic diseases (Mikton & Butchart, 2009). These consequences further have negative implications for public health and human development goals in the country – universal education and skills development.

The consequences affect children, families and societies in various ways including disruptions in schooling, development of antisocial behaviour, and costs of medical care, alternative care for children who are unsafe in their families and other services such as counselling. Countries will benefit from investing in programmes that promote safe and nurturing relationships between children and their parents or caregivers to stimulate cognitive development and prevent child maltreatment (Richter, 2006).

#### **1.4 Aims of the CMPR project at national and provincial level**

The aim of the child maltreatment prevention readiness study was to develop an instrument that would be used to assess prevention readiness in South Africa as one of the low-and-middle income countries. The level of prevention readiness can be measured at national, provincial and community levels. Assessing CMP readiness can serve several important purposes, including identifying major gaps in readiness and informing plans to address them, establishing a baseline measure against which progress in increasing readiness can be tracked, helping to allocate resources to increase readiness for CMP, assisting in matching an intervention to the existing level of readiness, and acting as a catalyst for taking action to prevent CM.

Such an instrument can serve the following purposes:

- 1) inform plans to increase readiness;
- 2) establish a baseline measure against which progress in increasing readiness can be tracked;
- 3) help allocate resources at the international, national, and provincial/state, and community levels to increase readiness for child maltreatment prevention;
- 4) assist in matching an intervention to the existing level of readiness;
- 5) act as a catalyst among relevant key players for taking action to prevent child maltreatment (CM); and
- 6) function as a teaching tool to introduce the concepts of CMP and CMPR in the child care sector.

The instrument will contribute to what Dawes, et al. (2006, p.12) refer to as the “gauges on the policy and welfare-planning dashboard” of the country and provinces.



### 1.4.1 Specific objectives of the study were to:

The specific objectives of the study were to:

1. Develop an integrated conceptual model for child maltreatment prevention readiness at national and provincial levels on the basis of which the instrument could be developed;
2. Develop an instrument to measure child maltreatment prevention readiness at the two levels;
3. Pilot the instrument;
4. Apply the developed instrument by conducting a field trial at the national level and in the Western Cape Province;
5. Determine the level of child maltreatment prevention readiness from key informants at national level and in the Western Cape Province; and
6. Outline strategies to increase child maltreatment prevention readiness in South Africa.

### 1.5 Target audience for the research

The target audience was government Departments of Social Development, health, education, community safety, local government, local child protection NGOs, international NGOs, funders, training institutions, research institutions; professional bodies, and municipalities. Representatives of some of these entities participated in the study at both the formative and implementation stages.

It was intended that decision makers and implementers of programmes should be able to use the identified theory-derived dimensions of child maltreatment prevention readiness (Mikton et al, 2011) to assess their own capacity to safeguard children's rights to survival, development, protection and well-being by financing, implementing and evaluating evidence based programmes for child maltreatment prevention.

## 2. Method

A workshop for research teams from the identified low-and-middle income countries (Brazil, China, Malaysia, Macedonia, Saudi Arabia and South Africa) was convened at WHO headquarters in Geneva in mid-2009. The aim of the workshop was to review the evidence-base for child maltreatment prevention and discuss its applicability in LMICs. The Human Sciences Research Council was invited together with other countries' research teams to develop, pilot and field test an interview schedule for assessing child maltreatment prevention readiness (CMPR).

The stages of the process for the development of the instrument are described below.

### 2.1 Development of the data collection instrument

The Readiness Assessment for the Prevention of Child Maltreatment (RAP-CM) is a method of assessing a country's readiness to implement evidence-based CMP programmes on a large scale and of generating recommendations to increase the country's readiness using two

instruments both based on the same 10-dimensional model (Box 1): (1) the Readiness Assessment for the Prevention of Child Maltreatment – Informants version (RAP-CM-I), which assesses the views of key informants using a semi-structured interview schedule with over 100 items; and (2) the Readiness Assessment for the Prevention of Child Maltreatment based on the expert opinion using all available data (RAP-CM-XD) which is a semi-structured interview schedule whose items mirror those of RAP-CM-I.

### **a) Literature review**

Literature review was conducted to develop a model for child maltreatment prevention readiness comprising ten dimensions, each with more than one facet. The model was discussed among the country teams in a workshop. It had the following dimensions: *problem assessment; mobilization to address the problem; human and technical resources; material resources; institutional resources and linkages; informal social resources; legislation, policies and plans, and programmes*. The model was then discussed in a focus group discussion with practitioners and academics in the Western Cape Province.

Box 1: The ten dimensions of RAP-CM

<p><b>Dimension 1:</b> <i>Attitudes towards child maltreatment and its prevention</i> – including, for instance, understanding of the difference between child maltreatment prevention and child protection; perceived priority of child maltreatment prevention, adequacy of measures taken to date to prevent child maltreatment.</p>
<p><b>Dimension 2:</b> <i>Knowledge about child maltreatment and its prevention</i> – including, for instance, the nature of, prevalence of, risk factors for, and consequences of CM, and the appropriateness of different prevention programmes.</p>
<p><b>Dimension 3:</b> <i>Existence of scientific data on child maltreatment and its prevention in the country</i>, e.g. data on magnitude &amp; distribution of CM; short and long term consequences of CM; risk and protective factors for and causes of CM; official definitions of CM; reporting systems.</p>
<p><b>Dimension 4:</b> <i>Existing child maltreatment prevention programmes and programmes into which CMP components could be integrated and outcome evaluations of these programmes</i>.</p>
<p><b>Dimension 5:</b> <i>Legislation, official mandates of governmental or non-governmental agencies, and policies relevant to CMP</i>.</p>
<p><b>Dimension 6:</b> <i>Will to address the problem including leadership, political will, public will, advocacy and communications efforts</i>.</p>
<p><b>Dimension 7:</b> <i>Institutional links</i> (e.g. coalitions, partnerships and networks dedicated to CMP) and resources of institutions involved in CMP.</p>
<p><b>Dimension 8:</b> <i>Material resources</i>, including funding, infrastructure and equipment.</p>
<p><b>Dimension 9:</b> <i>Human and technical resources</i>, including professionals with the required technical, administrative, and managerial skills, knowledge, and expertise and the institutions that enable the acquisition of such skills and knowledge.</p>
<p><b>Dimension 10:</b> <i>Informal social resources</i> (e.g. citizen participation, social capital, collective efficacy). When assessing readiness and capacity, it is generally considered as important to focus on the quality of social interactions and social bonds within a community or society as it is on specific assets for child maltreatment prevention readiness such material resources, and legislation and policies.</p>

### **b) Focus group discussion**

One focus group was constituted at the formative stage to provide feedback on the elements of the model developed based on literature review (Mikton, et al, 2011). The focus group included 8 experts currently or potentially involved in CM prevention from academia (e.g., psychiatry, psychology, education, law), NGOs (e.g., children’s rights foundations and groups), and various

government departments (e.g., Departments of Health; Social Development; Community Safety). The discussion was completed in 2½ hours. The aim of conducting a focus group discussion was to identify the model's strengths and weaknesses by determining the following:

1. Whether the model covered all the different aspects of readiness (i.e. abilities, capacities, resources, etc.) for the large-scale implementation of evidence-based child maltreatment prevention interventions in South Africa;
2. Dimensions, facets, and sub-facets that need to be added, deleted, changed, or expanded;
3. Whether some of the dimensions and facets should be grouped together differently;
4. Whether some of the dimensions and facets should be collapsed or perhaps further separated; and
5. The appropriateness of the model overall and of individual dimensions, facets, and sub-facets to the cultural context of South Africa, and any changes that should be made to make it more appropriate.

#### ***c) Interview schedule***

Based on the finalised integrated conceptual framework, a data collection instrument (RAP-CM-I) was developed (Appendix 1). RAP-CM is based on the definition of child maltreatment which was provided to all key informants on a card. It was further specified that child maltreatment can occur in many different settings and that perpetrators may be parents and other family members; caregivers; friends; acquaintances; strangers; others in authority – such as teachers, soldiers, police officers and clergy; employers; health care workers; and other children.

#### ***d) Cognitive testing***

The interview schedule was subjected to cognitive testing (see Waddington & Bull, 2007 on cognitive interviewing as a research technique) in a small group of social workers, planners and development workers in the child protection sector in the Western Cape Province. They worked for government and non-governmental organisations that implement the child protection mandate in the province. An attempt was made to ensure that the focus group discussion participants were representative of the prospective study participants.

The aim of the cognitive interviewing exercise in a focus group was to administer the draft interview schedule in order to assess:

- whether it was generating the information required;
- the quality (e.g. clarity, intelligibility) of the interview schedule;
- how interviewees elaborated their answers based on the specific contexts of their experiences and actions in order to assess the reliability of the questions;
- how they interpreted the questions and recollected events in their roles; and
- to identify any difficulties and problems with the questions.

This testing process established a range of question interpretations among focus group participants and their reasoning. The instrument was revised on the basis of feedback from the cognitive testing process.

### ***e) Pilot study and questionnaire adaptation***

The revised interview schedule (RAP-CM-I) was pilot tested among a purposively selected group of twenty (20) practitioners in government, non-governmental organisations and academics in the Western Cape Province. The purpose was to improve on clarity of the questions and to shorten what was a rather long questionnaire, to make it more practical for fieldwork.

The findings from cognitive testing and pilot testing were shared with other countries' research teams.

The interview schedule (RAP-CM-I) was finalised and adapted to the South African context for field trial at the national level and in the Western Cape Province context. But the interview schedule was not translated from English to other official languages because all study participants were fluent in the English language.

## **2.2 Field trial**

The design included three components: the country assessment which entailed review of various socio-economic indicators, focusing on child well-being and development in the country. The second component was to interview key informants using the interview schedule (RAP-CM-I). The third component of the study was referred to as "literature-based assessment" and entailed a desk review of the literature about the situation of child protection in the country. Based on the literature and consensus, three researchers completed a replica of the interview schedule (which excluded dimensions 1 and 2) that was used to interview key informants (RAP-CM-XD). RAP-CM-XD was completed by the research team after conducting the interviews of key informants with RAP-CM-I using all available data relevant to CMP in the country data – obtained from both the interviews with key informants and collected from other sources. The first author reviewed the literature and identified factual information supporting each response (where such information was available). The second and third author looked at the responses and made further comments leading to a consensus about appropriate scores. There was no inter-rater reliability evaluation conducted to estimate consistency of scores.

The use of RAP-CM-XD and RAP-CM-I in combination offered the following advantages. First, RAP-CM-XD produced an assessment that was as accurate as possible of those dimensions of readiness which are primarily factual – Dimension 3 (scientific data), Dimension 4 (programmes), Dimension 5 (legislation, mandates, and policies), Dimension 7 (institutional links and resources), Dimension 8 (material resources) and to an extent Dimension 9 (human and institutional capacity) – and an assessment of the remaining dimensions that is informed by factually correct information. Second, RAP-CM-I allows the perceptions, attitudes, underlying beliefs, knowledge, and opinions of those individuals who have or are likely to have significant influence on decision-making and power over child maltreatment prevention in the country to be evaluated, partly by measuring them against the factually more accurate findings of RAP-CM-XD. The assumption is that the readiness of a country to scale up the implementation of CMP programmes is largely dependent on the perceptions, attitudes, underlying beliefs, knowledge, and opinions of the key actors in the field in any country concerning CM. Comparing RAP-CM-XD against RAP-CM-I allows discrepancies – particularly on the more factual dimensions – to be identified and the gaps in key actors' knowledge, perceptions, attitudes, underlying beliefs,

and opinions of key actors which might impede the implementation of CMP programmes on a large-scale to be highlighted.

In addition, an assessment of "key country conditions" related to population, health, socioeconomic inequality, social welfare, education, and child wellbeing that influence the implementation of large-scale prevention programmes for child maltreatment was conducted through a review of official (government and UN mainly) and academic secondary sources. These country attributes are discussed in the background section of the report.

### **2.3 Sampling procedure used to identify participants, recruitment, response rate, sample characteristics**

Interviewees were selected purposively to represent a variety of state, government, non-governmental, academic, research, civil society organisations and international agencies that have child welfare and development mandate at national and provincial level. The criterion was that the organisations should be currently providing child maltreatment prevention programmes or have programmes that can *potentially* integrate child maltreatment prevention into their existing services. Participants were recruited from the health (non-communicable and chronic diseases, child and adolescent health), social welfare, law-making institutions, university teaching departments and research units; NGOs that provide child protection and care programmes; as well as UN agencies and international NGOs (Appendix B). The interviewees were professionals and leaders in these agencies were selected because of their expertise, current or potential role in the child care and protection field.

Study participants were first contacted by telephone and were recruited by subsequently sending them a letter by electronic mail inviting them to participate in the study.

The key informant interview took approximately an hour to complete; RAP-CM-XD was completed by the research team after conducting the interviews of key informants with RAP-CM-I using all available data relevant to CMP in the country data – both gleaned from the interviews with key informants and collected from other sources. In addition, data on key country conditions – such as income level, per capita GDP, Gini index, adolescent fertility rate – with a potential bearing on the country's readiness to implement child maltreatment prevention programmes were also collected.

#### **Response rate**

Not all potential interviewees who were contacted took part in the study. A total of 52 potential participants were selected and 11 refused; giving a 78.8 percent response rate. While the response rate was high, the sample is not representative of all key stakeholders by sectors. In particular, despite the potential and actual role of the Department of Health in child maltreatment prevention, only one out of four Department of Health interviewees selected was interviewed. There were challenges in organising interviews with some of these key officials: they could not participate in the research without their managers' permission and the managers could not be accessed; and they suggested alternative respondents because their view was that their responsibilities did not include child maltreatment prevention; and they did not agree to any scheduled times for interviews.

### **2.4 Data analysis**

Quantitative data was managed and analysed using the Statistical Package for the Social Sciences (SPSS version 16) and Microsoft Excel.

Frequency distributions were determined to describe different aspects of the sample including the socioeconomic characteristics and responses to various interview schedule items.

In addition, the responses of each interviewee to all questionnaire items were scored on a scale of 0 to 2 with 0 corresponding to a response showing a lack of an attribute or negative evaluation of a situation; 1 to a low level of an attribute; and 2 to the most positive evaluation of a situation or indication of the highest possible level of an attribute. Each respondent's total score for each dimension was calculated, average scores for each of the 10 dimensions for all interviewees was determined, the average score for each category of data source, namely; all interviewees, national and provincial interviewees (RAP-CM-I), and researchers (RAP-CM-XD); as well as calculate differences between the scores on dimensions for RAP-CM-I and RAP-CM-XD.

Qualitative data was analysed thematically and integrated with the quantitative analysis for each dimension. Direct quotations were used to highlight various themes and contextualise quantitative responses.

Data analysis was done at different levels. The data was analysed globally combining both national and provincial responses to provide the overall country scores. In addition, the overall country scores by decision makers and practitioners were compared for national and provincial levels. Finally, the scores of study participants were compared with the "literature-based" responses compiled by the researchers.

The assessment process results in an overall score out of 100 for RAP-CM-I and RAP-CM-XD; a score out of ten on each of the ten dimensions for RAP-CM-I and RAP-CM-XD, which can be represented on a radar diagram (Figure 1); a comparison of findings from RAP-CM-I and RAP-CM-XD; and a list of proposed recommendations to increase readiness.

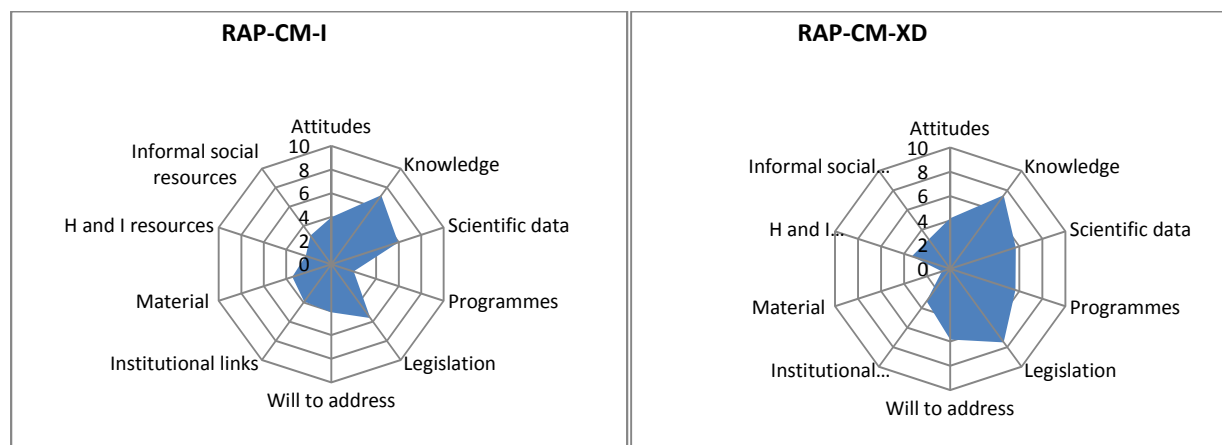


Figure 1: A radar diagram showing comparisons of findings from RAP-CM-I and RAP-CP-X, South Africa

### **Missing data**

One hundred and eight items out of 152 in the interview schedule (71%) were answered by 90% or more key informants. About 44 items (29%) were not responded to by 10% or more respondents. There were only a few high missing values which were not due to a skip rule. The highest non-responses were in relation to implementation of programmes.

*High missing values for programmes items without a skip rule*

- Level at which named child maltreatment programmes are implemented (national, sub-national or community (32%-80%))
- Outcome evaluation undergone (50%-90%)
- Level (national, sub-national or community) at which current or past child maltreatment prevention programmes were situated, and into which maltreatment prevention components could be integrated (85%).

## **2.5 Sample description**

A sample consisting of 41 policy makers, professionals, researchers and practitioners who work in the fields of child rights, care, protection and health in South Africa were interviewed. The aim of the face-to-face interviews was to obtain interviewees' perceptions of the country's readiness to implement large-scale child maltreatment prevention interventions. Participants worked for government departments and non-governmental organisations that have roles in child policy and child care at the national and provincial level in the Western Cape Province.

The majority of the interviewees (25 or 61%) were based at provincial level, while 16 (39%) worked for organisations with national mandate or programme coverage.

The majority of interviewees worked for government (40%). They were followed by individuals working for non-governmental organisations (30%) and those working for university and research institutions (22.5%). Representatives of international agencies were 5% of the sample.

Interviewees included heads of departments, directors, programme managers, programme coordinators, social work practitioners and researchers (training and advocacy).

A high majority of the participants were female while males represented less than one-fifth of the sample.

The following section analyses the overall national scores of child maltreatment prevention readiness for South Africa. Firstly, the analysis shows combined scores for all the 41 interviewees (national and provincial respondents) on each of the ten (10) dimensions, and in comparison with the scores based on the reviewed literature. Second, the analysis of the scores of the national and provincial interviewees shown separately for each dimension is presented.

## Findings

### 3. Overall score of child maltreatment prevention readiness

The primary aim of RAP-CM is to assess the perceptions, attitudes, underlying beliefs, opinions, and knowledge concerning CMP of key informants, who are the main actors in CMP in the country and at the provincial level. The following are the results of the assessment process based on the key informants responses.

The assessment process results in an overall score out of 100 for RAP-CM-I and RAP-CM-XD; a score out of 10 on each of the ten dimensions for RAP-CM-I. Overall, the South African score shows a low level of child maltreatment prevention readiness (CMPR).

#### 3.1 Scores on RAP-CM-I

With each of the ten scales scored out of ten, the sample of 41 interviewees provided scores that came to an average of 41.43 for all the 10 dimensions of CMPR. Figure 2 shows the average scores of the sample of key informants in South Africa for each dimension of the CMPR model on a scale of 0 to 10.

The scores ranged from 2 points for dimension 4 (existence of actual CMP programmes and programmes into which CMP components could be integrated and their outcome evaluation) to 7.2 points for dimension 2 (knowledge about child maltreatment and its prevention – including the nature of, prevalence of, risk factors for, and consequences of CM, and the appropriateness of different prevention programmes for different types of CM).

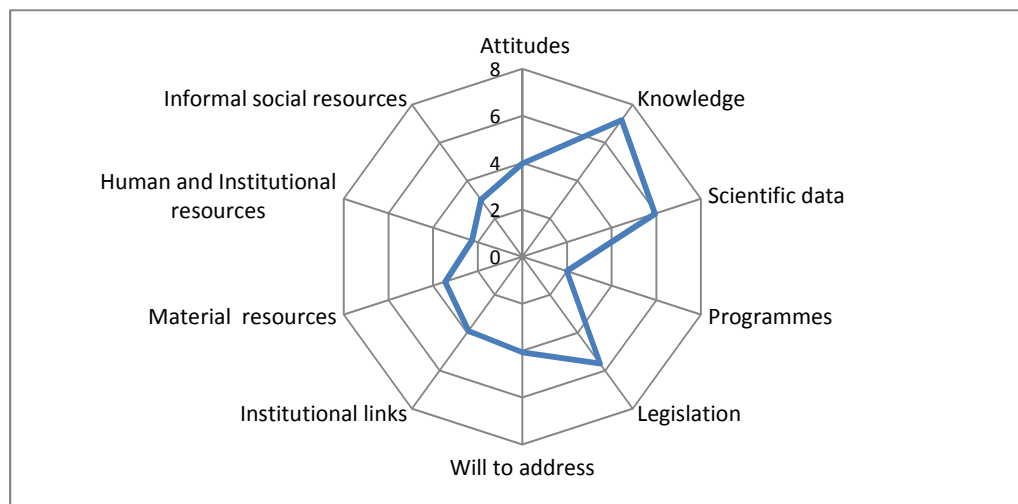


Figure 2: A radar diagram showing comparisons of findings from RAP-CM-I, South Africa



Low scores were indicated for existence of CMP programmes and programmes in the country or in the province into which CMP components could be integrated and their outcome evaluation (**dimension 4**) with a score of 1.99, availability of human resources and institutional resources to implement child maltreatment prevention – professionals with the required technical, administrative and managerial skills, knowledge and expertise and the availability of institutions that enable the acquisition of such skills and knowledge (**dimension 9**) – a score of 2.26 and informal social resources – citizen participation, social capital and collective efficacy (**dimension 10**) – with a score of 3.

The majority of the dimensions scored moderately low, that is, between 3.5 and 6 points out of a possible 10. The key informants scores for material resources including funding, infrastructure and equipment (**dimension 8**) was 3.46; institutional links including coalitions, partnerships and networks dedicated to CMP and resources of institutions involved in CMP (**dimension 7**) was 3.91; their attitudes towards child maltreatment and its prevention, including the difference between child maltreatment prevention and child protection; perceived priority of child maltreatment prevention; adequacy of measures taken to date to prevent child maltreatment (**dimension 1**) was 3.97; and the will to address the problem of child maltreatment including leadership, political will, public will, advocacy and communications efforts (**dimension 6**) was 4.07.

Moderate scores were obtained for legislation including official mandates of governmental and non-governmental agencies, and policies relevant to CMP (**dimension 5**) with a score of 5.63. It was followed by existence of scientific data on child maltreatment and its prevention in the country or in the province including data on magnitude and distribution of CM, short and long-term consequences of CM, risk and protective factors for and causes of CM, official definitions of CM, and reporting systems (**dimension 3**) with a score of 5.94.

The only high score was for knowledge about child maltreatment and its prevention (**dimension 2**) – 7.2 points.

### 3.2 Scores on RAP-CM-XD

The following is an analysis of South Africa's child maltreatment prevention readiness based on the scores for the 10 dimensions on RAP-CM-XD. The overall "literature-based" score – RAP-CM-XD for child maltreatment readiness based on the researchers' assessment of the situation in the country is 46.7/100. The score indicates that South Africa had a low level of readiness to implement child maltreatment prevention programmes on a large scale. South Africa was scored highest on dimension 2 (knowledge) and dimension 5 (legislation) and other moderately high scores were on dimension 3 (scientific data), dimension 4 (programmes), and dimension 6 (will to address the problem) – Figure 3. South Africa scored lowest on dimension 8 (materials).

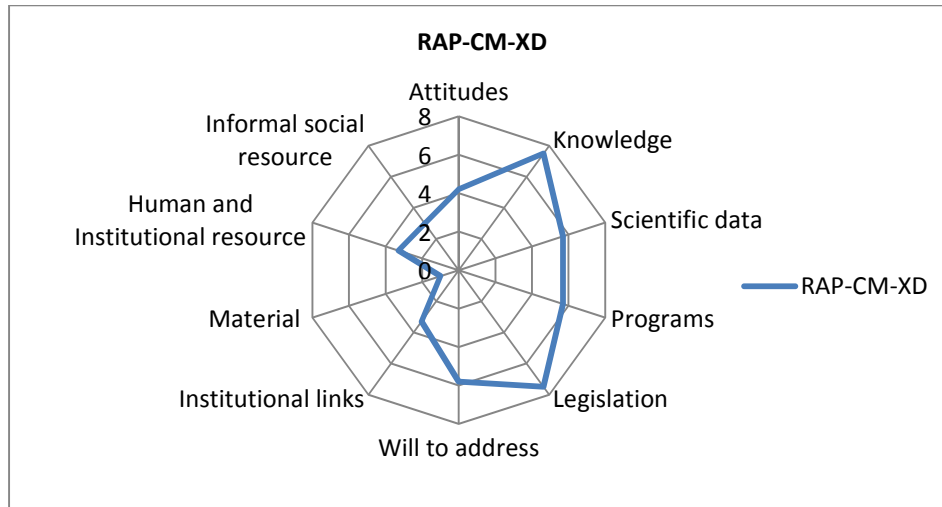


Figure 3: A radar diagram showing comparisons of findings from RAP-CM-XD, South Africa

### 3.3 Overall comparison of each dimension of RAP-CM-I and RAP-CM-XD

The secondary purpose of the RAP-CM-I was to glean factual information and references to sources of further factual information from the key informants, which was then followed-up by the research team and used for the assessment using RAP-CM-XD. The RAP-CM-XD scores would be assumed to be the highest possible scores for individual dimensions and overall, if they were entirely based on the assessment of the available information in the country. However, not all the dimensions concerned exclusively factual information and some of the factual information from grey literature would not be accessible to researchers, it formed part of institutional memory.

The following is a comparison of RAP-CM-I and RAP-CM-XD scores.

The overall “literature-based” score – RAP-CM-XD for child maltreatment readiness based on the researchers’ assessment of the situation in the country is 46.7/100 compared with 41.4 obtained from the RAP-CM-I assessment (Table 1). The overall score from the assessment based on the RAP-CM-XD, completed by the researchers, shows a total score higher than that of the key informants. However, based on the literature and key informants perspectives, there is a generally low level of child maltreatment prevention readiness in South Africa.

The following is an analysis of South Africa’s child maltreatment prevention readiness based on the scores for the 10 dimensions on RAP-CM-I and RAP-CM-XD.

RAP-CM-XD scores were higher than those for RAP-CM-I on four of the 10 dimensions, namely, dimensions 4, 5, 6, and 9. They were lower than for RAP-CM-I on two of the ten dimensions (dimensions 7 and 8), and equal on four of the 10 dimensions (dimensions 1, 2, 3 and 10), (Table 1 and Figure 4). Higher scores for RAP-CM-XD than RAP-CM-I on dimensions 4, 5, 6, and 9 (programmes; legislation; will to address CM; and availability of human resources and institutional resources that enable the acquisition of such skills and knowledge) indicated the concerns of most of the key informants involved in policy, research and practice.

Table 1: Comparison of RAP-CM-I and RAP-CM-XD scores for each dimension, South Africa

	Attitudes	Knowledge	Scientific data	Programs	Legislation	Will to address	Institutional links	Material	Human and Institutional resource	Informal social resource	Total score
RAP-CM-I	3.97	7.2	5.94	1.99	5.63	4.07	3.91	3.46	2.26	3	41.4
RAP-CM-XD	4.2	7.5	5.7	5.7	7.5	5.8	3.3	1	3.3	3	47

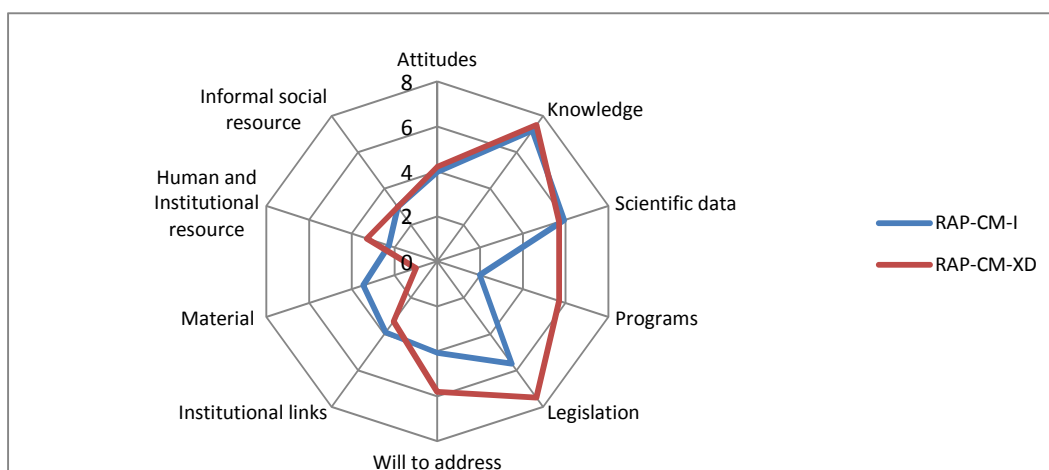


Figure 4 Comparison of RAP-CM-I and RAP-CM-XD scores for each dimension, South Africa

While some of the dimensions showed similar scores, other dimensions showed marked differences between how the key informants perceived the level of South Africa's readiness to implement large-scale CM prevention programmes and the assessment by the researchers based on available evidence.

Analysis of the differences between RAP-CM-I and RAP-CM-XD scores show no differences or slight differences ( $\leq 2$  points) on the majority of the dimensions: dimensions 1 (attitudes); 2 (knowledge); 3 (scientific data); 5 (legislation); 6 (will to address); 7 (institutional links) and 10 (informal social resources). Apart from dimensions 1 (attitudes, which the research team did not score) and 6 (will to address problem), all the other dimensions with a small difference between RAP-CM-I and RAP-CM-XD addressed predominantly factual information. Therefore, the small differences between the two measures on these dimensions show that there was congruency between interview derived data and secondary sources on most dimensions including those largely factual dimensions. Large differences were obtained for two dimensions – dimension 4 (programmes) and 8 (material resources) with a difference of  $\geq 2$  points (Table 2).

Table 2 Differences between RAP-CM-I and RAP-CM-XD scores and means

Dimensions		RAP-CM-I score	RAP-CM-XD score	Differences between RAP-CM-XD and RAP-CM-I ( <i>RAP-CM-XD - RAP-CM-I</i> )	Mean of RAP-CM-I and RAP-CM-XD
1	Attitudes	4	4.2	0.2	4.1
2	Knowledge	7.2	7.5	0.3	7.4
3	Scientific data	5.9	5.7	-0.2	5.8
4	Programmes	2	5.7	3.7	3.8
5	Legislation	5.6	7.5	1.9	6.6
6	Will to address	4.1	5.8	1.7	5
7	Institutional links	3.9	3.3	-0.6	3.6
8	Material resources	3.5	0.7	-2.8	2.1
9	Human & Institutional capacity	2.3	3.3	1	2.8
10	Informal social resources	3	3	0	3
	<b>Total</b>	<b>41.4</b>	<b>46.7</b>	<b>5.2</b>	<b>44.2</b>

The key informants' concerns were about the inadequate capacity of the Department of Social Development to implement the provisions of the Children's Act (38 of 2005, as amended), and that the relevant legislation was only enacted recently, thus making it impossible to meaningfully evaluate its impact. On the other hand, higher scores on programmes and legislation on RAP-CM-XD were influenced by two considerations. Firstly, the recognition that the legislation introduced for the first time in the history of child protection in South Africa, is intended to reduce reliance on statutory services and promote the care of children in families through primary prevention and early intervention services (see Matthias & Zaal, 2008). Secondly, primary prevention programmes have been part of the policy discourse since 1997 following the adoption of the White Paper for Social Development (South Africa, 1997). The White Paper emphasised the needed to shift from the clinical and individualised approaches to social welfare, to rights-based and developmental solutions to the problems of families with children.

Furthermore, significant strides have been made in relation to providing care for children in families and empowering communities to support a large proportion of children orphaned and made vulnerable by HIV and AIDS. But there is a gap of programmes that conceptualise child maltreatment as a social problem that cuts across social class and different types of family, and address the risk factors known to make children vulnerable to maltreatment. The determination to address the needs of children made vulnerable by HIV and AIDS provides lessons for approaches to addressing other forms of risk.

The problem of human resources is commonly assessed in relation to a lack availability of social work skills and high case loads. It was not surprising for the key informants to view availability of human resources and institutional resources as inadequate especially if the ideal professionals needed for functioning programmes were social workers competent to deliver statutory

measures for children reported as affected by maltreatment. There was a chronic shortage of these professionals in the country and human resources presented a serious challenge for policy implementation. Expansion of services to the majority of the population who were previously excluded exacerbated the human resources problem. But the issue of availability of human resources and institutional resources for CMP was critically assessed. Primarily there have been shifts in policy with regard to the kind of skills needed to provide care for children. They include the broadening of categories of social care professionals to include non-social work professionals, particularly the recognition of child and youth care workers and auxiliary social worker training services. The potential role of other non-traditional categories of community work practitioners now that there is improvement in terms of the placing of child maltreatment prevention services in policy is key to implementation of prevention measures. Historically these skills supported social welfare services other than prevention and early intervention, and this approach still dominated the outlook and practice of many actors in the field in South Africa. Gray and Lombard (2008) argue that the human resources challenge has partly been improved by implementing the training of various occupational groups stated in the White Paper for Social Welfare (South Africa, 1997). They include child and youth care workers, community development workers and probation workers. Of equal strategic significance is the policy focus on early childhood development in the country and the consensus on a national psychosocial support framework for vulnerable children, the Isibindi model. The government partnered with UNICEF to introduce parenting skills training nationally as part of the expansion of Early Childhood Development (UNICEF South Africa, 2010).

The Department of Social Development supports the training of social auxiliary workers offered by several accredited private service providers in the country. The Department identifies social auxiliary workers as a cadre of social work professionals who provide services under the supervision of a social worker. Social auxiliary worker or community health care workers provide services for prevention, education and development programmes. They can work for government agencies and NGOs that provide social welfare services but are particularly needed to expand service delivery to previously under-served populations. ([http://www.dsd.gov.za/index2.php?option=com\\_docman&task=doc\\_view&qid=82&](http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&qid=82&)).

RAP-CM-XD scores on dimensions 7 (institutional links e.g., coalitions, partnerships and networks dedicated to CMP) and resources of institutions involved in CMP) and 8 (materials including funding, infrastructure and equipment) were lower than RAP-CM-I scores. The key informants could identify a number of partnerships, alliances, coalitions or networks of institutions some of which were not published. Although documents in the grey literature were requested during the interviews, the relevant documents were not readily available or the key informants were not aware of such documents. A thorough analysis that entails a review of various records including organisational minutes of meetings, brochures for various campaigns and memoranda would be some of the grey literature sources that would provide additional information, but such analysis would be resource intensive.

Clearly, the optimal benefits of this strategy will depend on a coherent child maltreatment prevention strategy. There is still a disjuncture between policy pronouncements made since 1997 (The White Paper for Social Welfare) regarding a shift towards prevention programmes (Matthias & Zaal, 2008) and implementation of child protection with emphasis on early intervention and tertiary child protection services. Practitioners and programme managers agree that historically more resources have been allocated for statutory care services than for primary prevention programmes (Makoae, Tamasane & Mdakane, 2009), mainly because there is a lack of prevention programmes and a few available are provided at small scale. Tomlinson's and

colleagues' research has shown high prevalence of maternal mental health problems (depressive mood) in pregnant women in resource poor communities that placed the wellbeing, health and development of a child at risk (Cooper, Tomlinson, et al , 1999; Hartley, Tomlinson et al, 2011; Honikman, van Heyningen et al, 2012). Interventions such as Philani Mentor Mothers project (PMMP) and the Perinatal Mental Health project (PMHP) both implemented in Cape Town, show that screening women during pregnancy and postpartum period while supporting them through referral services enhances the quality of mother-infant relationships. Berg (2012) found that there was a relationship between child's failure to thrive and maternal depression. But primary health care services in South Africa do not provide routine psychosocial services for mothers of infants attending primary health services.

With the enactment of the Children's Act in the past six years, children's social services have been systematically assessed as part of monitoring the implementation of the Act by provinces, and the Children's Institute of the University of Cape Town has published several reports on these budget assessments. This literature identifies the challenges of assessing the adequacy of public funding for children's social services under the Department of Social Development in general, and for child protection services in particular. Proudlock (2012) indicated that a lack of disaggregation of budgets for care, development and protection sub-programmes at provincial level made it difficult to assess how much was allocated specifically for child protection. This would be even more difficult when assessing funding and material support for child maltreatment prevention programmes given the lack of distinction between prevention and responsive sub-programmes in DSD and budget allocations for NGOs that design and implement child protection services. Nevertheless, the roll-out of the Isibindi programme for children at risk in 2012 marked the first major attempt to provide a large-scale programme with a focus on prevention. The programme trains child and youth care workers who provide services to children living in child-headed households as well as train older siblings on the care of younger siblings to alleviate the need for out-of-home care and is implemented in areas highly affected by HIV and AIDS ( Treasury, 2012; Parliament, 2012).

### 3.4 Comparison of overall National and Western Cape Province child maltreatment prevention readiness scores

The majority of the key informants were female (83%) and 17% were male. The majority of the interviewees 25 (61%) were based at provincial level in the Western Cape Province compared with 16 (39%) who worked for organisations with national mandates or coverage. Of the 40 key informants who specified the type of organisation they were working for, 16 (39%) were working for government (administration) and 24 worked for other organisations in the country (Table 3).

Table 3 Gender of key informants and type of organisations they worked for, at national or Western Cape Province level

		National	WC* Province
Gender of participants	Male	3	4.0
	Female	13	21.0
	<b>Total</b>	<b>16</b>	<b>25.0</b>
Type of organisation	Government	8	8
	NGO	3	9
	International organisation	2	0
	University	2	7
	Other (e.g. school)	0	1
<b>Total</b>	<b>15</b>	<b>25</b>	

\*WC is Western Cape

A comparison of the scores of national and provincial key informants shows that both categories scored high on dimension 2 (knowledge) and dimension 3 (scientific data). National interviewees also scored legislation high while provincial interviewees scored legislation low. The key informants from both national and provincial levels scored dimension 4 (programmes) lowest followed by availability of human and institutional resources for implementing child maltreatment prevention (Table 4 and Figure 5).

Table 4 Differences between RAP-CM-I national and RAP-CM-I provincial scores and differences

	1	2	3	4	5	6	7	8	9	10	Total
<b>N</b>	<b>3.5</b>	<b>6.9</b>	<b>5.9</b>	<b>2.1</b>	<b>6.4</b>	<b>4.3</b>	<b>4.3</b>	<b>3.3</b>	<b>2.4</b>	<b>3.2</b>	<b>42.3</b>
<b>P</b>	<b>4.2</b>	<b>7.4</b>	<b>6.0</b>	<b>1.9</b>	<b>4.1</b>	<b>3.9</b>	<b>3.7</b>	<b>3.5</b>	<b>2.2</b>	<b>2.9</b>	<b>39.8</b>
<b>D</b>	<b>-0.7</b>	<b>-0.5</b>	<b>-0.1</b>	<b>0.2</b>	<b>2.3</b>	<b>0.4</b>	<b>0.6</b>	<b>-0.2</b>	<b>0.2</b>	<b>0.3</b>	<b>2.5</b>

N= National; P= Provincial; D= Difference between N and P, N – P.; 1= Attitudes; 2= Knowledge; 3= Scientific data; 4= Programmes; 5= Legislation; 6= Will to address; 7= Institutional links; 8= Material; 9= Human and institutional resources; 10= Informal social resources.

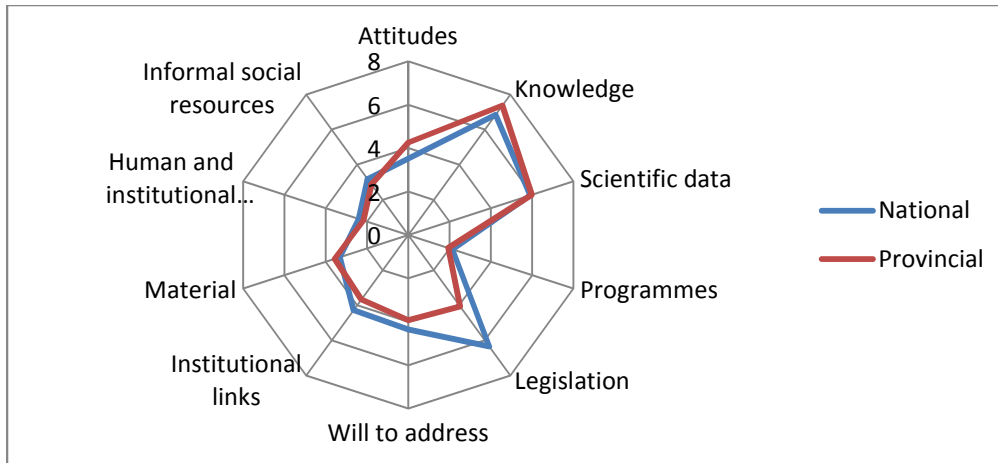


Figure 5 Comparison of RAP-CM-I National and RAP-CM-I Provincial scores for each dimension, South Africa

The patterns of scores by the two categories of key informants were consistent for all the dimensions except dimension 5 (legislation) where the difference between the national and provincial RAP-CM-I was >2 points.

#### 4. Scores on individual dimensions of RAP-CM-I for national and provincial respondents

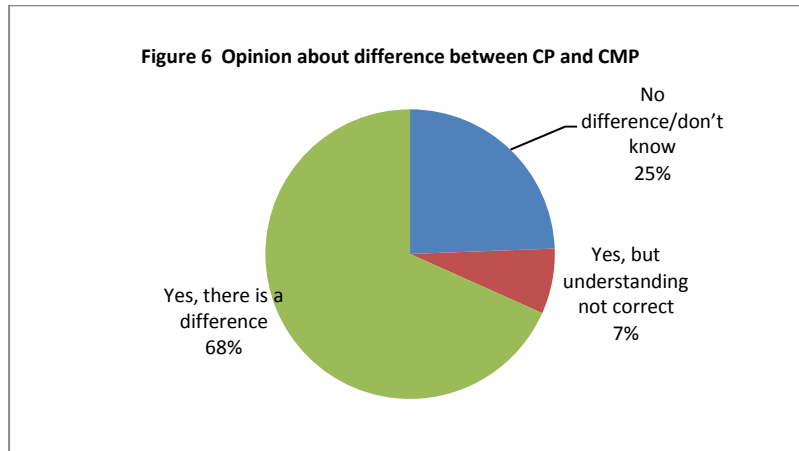
The following is a more detailed analysis of individual items of the 10 dimensions based on the quantitative scores and qualitative responses of the key informants.

##### 4.1 Dimension 1: Attitudes

Key informants were asked if they perceived differences between child maltreatment prevention and child protection. They were also asked if in their opinion such a difference existed, to explain what it consisted of.

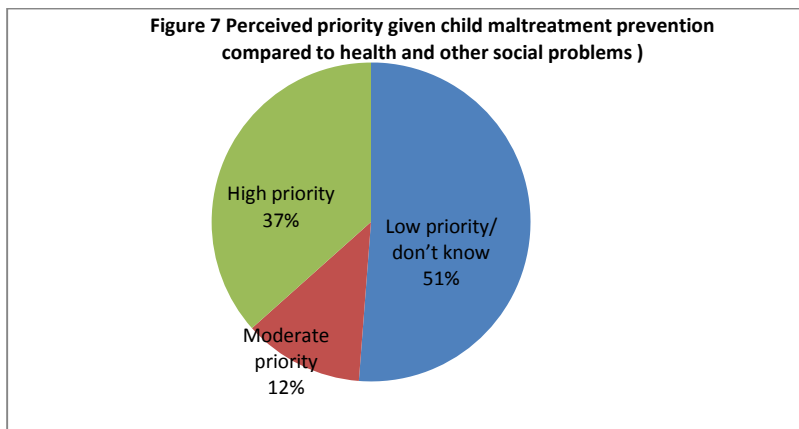
The majority of respondents (68.3%) stated that there was a difference between child protection (CP) and child maltreatment prevention (CMP) and their understanding of each approach was correct. About 24.4 % of the respondents mentioned that there was no difference between the two approaches. Only very few (7.4%) of the interviewees perceived the two approaches as different but did not have correct understanding of the difference (Figure 6).



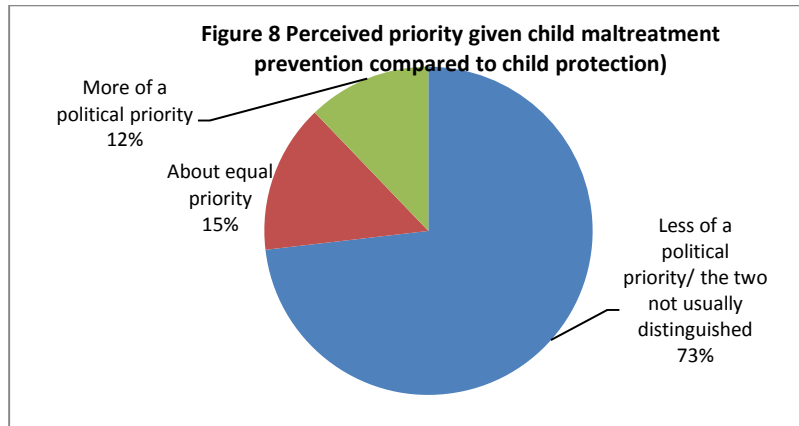


Some of the respondents who perceived the two approaches as different, however, questioned the validity of drawing or emphasising such distinction between child protection and child maltreatment prevention. Their explanation was that in South Africa, child protection was an all-encompassing practice. They pointed out that child protection was inclusive of child maltreatment prevention and both lay on the continuum of the child care policy. They also described the former as an “umbrella” construct that includes both prevention and responses to child abuse.

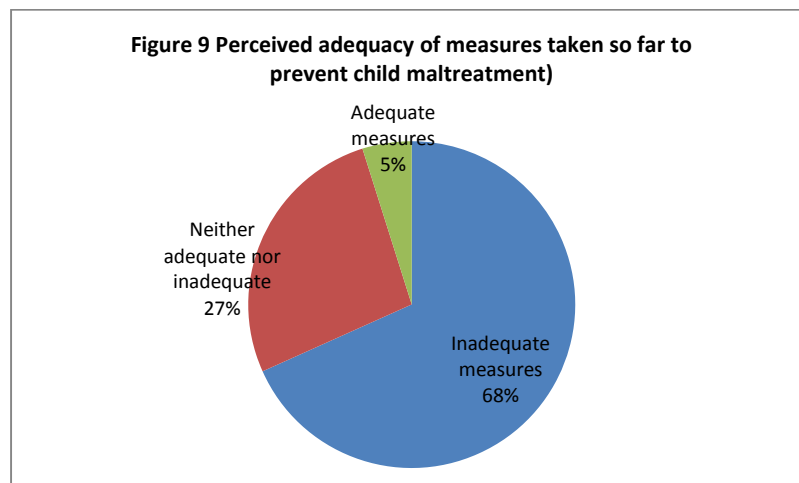
Most of the participants (51%) believed that child maltreatment prevention was given low priority compared to other health and social problems. Only 37% believed that taking measures to prevent child maltreatment before it occurred was of high priority (Figure 7).



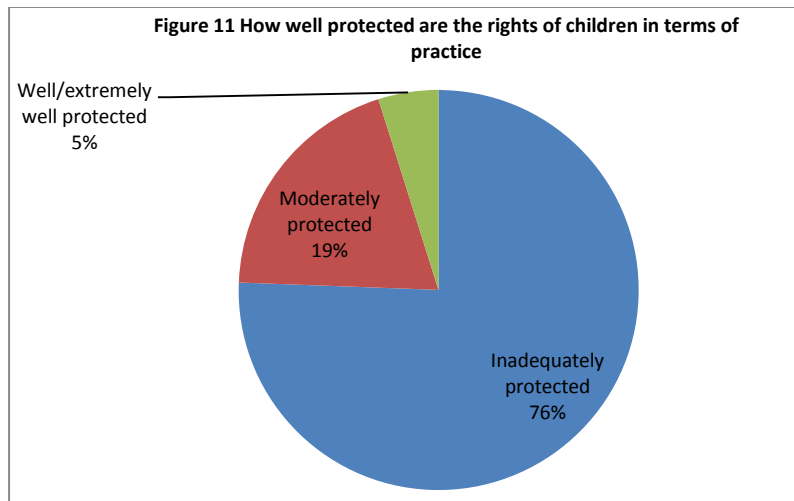
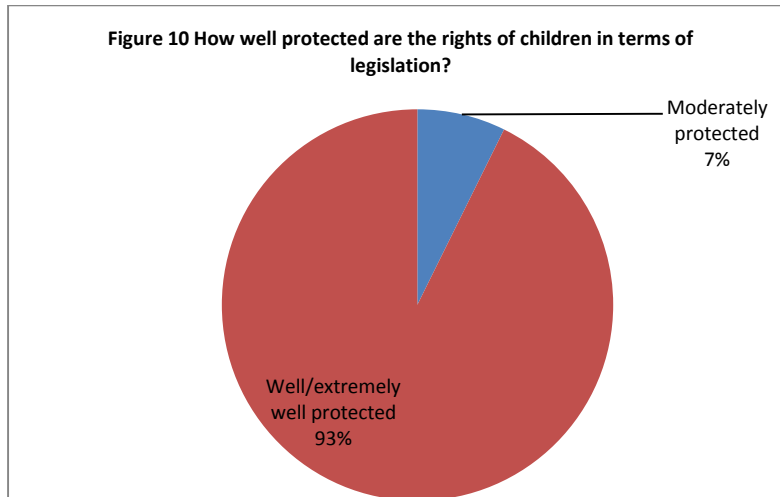
Interestingly, despite 37% of the interviewees stating that child maltreatment prevention was a policy priority compared with other health and social problems, and 25% who did not think child protection and child maltreatment prevention were different, only 12% of the interviewees believed that intervening to prevent child maltreatment before it occurs was of political priority in South Africa. Majority of the interviewees (73%) stated that prevention was less of a political priority compare with child protection (that is responding to child maltreatment once it has occurred) or that the two approaches were not usually distinguished (Figure 8).



The dominant perception that child maltreatment prevention is not prioritised in the political agenda is further indicated by the interviewees' view that to date, measures taken to prevent child maltreatment were inadequate. More than two-thirds (68%) of the interviewees stated that the measures were inadequate compared to only 5% saying the measures were adequate (Figure 9).



There are major differences between the extent to which the country has promulgated legislation that protects children and the degree to which the rights of children are protected in practice. While a high majority of interviewees believed that legislation was adequate (93%), there were many of them (76%) who did not find it effective in protecting children (Figure 10 and Figure 11).



There was agreement between the interviewees and the researchers' assessment concerning the prioritisation of child maltreatment prevention currently compared to other social and health problems. Even though policy explicitly prioritises prevention measures for vulnerable children there are significant gaps in policy implementation. The major barrier to developing effective prevention measures is that child maltreatment prevention is either not distinguished from child protection, or the latter receives more consideration when it comes to allocation of public resources. The key legislation and policy direction provided by the White Paper for Social Welfare (South Africa, 1997) and the Children's Act (No. 38 of 2005, as amended) require to be supported by budget allocations clearly marked for the implementation of prevention programmes. There is clear evidence that the current measures including early intervention and statutory care services are not likely to improve the situation of children at risk of child maltreatment because the measures are not designed to prevent the incidence of cruelty to children before it occurs. Awareness of officials and practitioners responsible for financing and designing child care and protection programmes about the difference between child

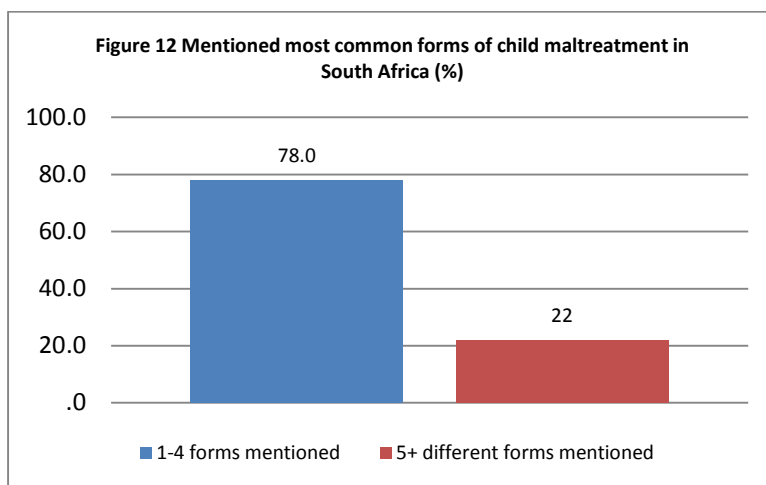
maltreatment prevention and child protection approaches in addressing child maltreatment is crucial for practice to shift towards the former.

## 4.2 Dimension 2: Knowledge of child maltreatment prevention

The interviewees' knowledge of child maltreatment and its prevention were assessed by asking them about the nature, magnitude, consequences and costs of child maltreatment. They recorded high scores for this dimension at >6 points.

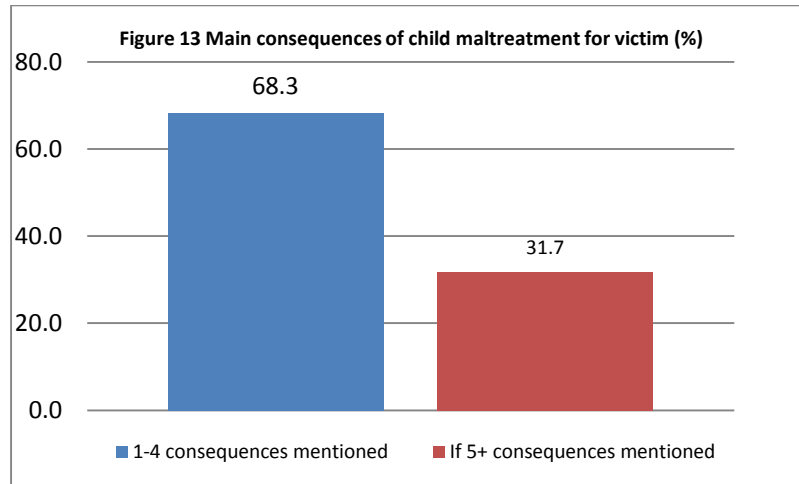
The majority of the interviewees believed that a significant proportion of adults in South Africa experienced childhood maltreatment. About 31.7% believed that 25-49% of current South African adults were maltreated during childhood. About 27% thought that the proportion of adults maltreated in childhood was higher at 50-74% of the adult population; while 14.6% of the respondents believed that as high as three quarters to almost everyone in the adult population had experienced some form of maltreatment during their childhood. About 24% of the respondents could not estimate the proportion of such adults.

The majority of interviewees (78%) identified between one and four forms of child maltreatment as most common in South Africa (Figure 12). Of the 78% of the interviewees who identified at least one form of child maltreatment as common, majority identified child sexual abuse (75%), child physical abuse (72%), and neglect and negligent treatment – lack of access to basic housing, abandonment and nutritional neglect (66%). Psychological or emotional abuse was mentioned by about 38% of the interviewees.



### 4.2.1 Knowledge about consequences

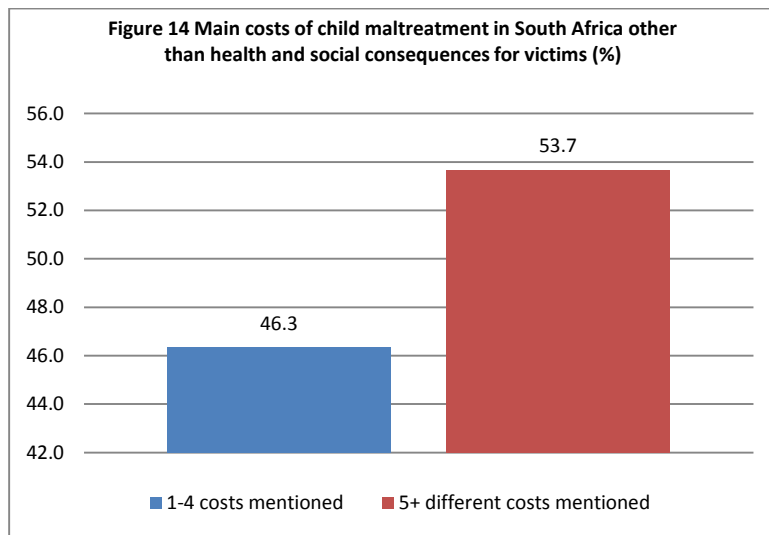
The interviewees showed a good knowledge of child maltreatment consequences for the victim. About 68% of them stated 1 to 4 consequences of child maltreatment for victims with about 32% mentioning 5 and more consequences (Figure 13). However, most of the interviewees could not draw a distinction between the four broad types of child maltreatment consequences namely *injuries, health risk behaviours, mental and social problems* and *chronic diseases*. Instead most of them mainly showed good knowledge by identifying the specific examples of these types of the consequences. In particular, participants showed inadequate knowledge about the health and social consequences of child maltreatment for victims.



#### 4.2.2 Knowledge about main costs

The key informants were also asked to state what they considered to be the main costs of child maltreatment other than the health and social consequences for the victims. The objective was to establish their knowledge in relation to the three broad types of costs – *direct medical costs*, *direct non-medical costs* and *indirect costs*.

Most interviewees, about 54% could identify 5 or more main costs of child maltreatment (Figure 14). The participants primarily perceived costs of child maltreatment in terms of its impact on the service system.



#### 4.2.3 Direct medical costs

Glaringly, only a few key informants (6) identified the direct medical cost of child maltreatment for society. They identified hospitalisation, trauma, therapeutic and counselling costs provided to

victims and family members. Responses tended to be less elaborate than in relation to direct non-medical and indirect costs.

#### **4.2.4 Direct non-medical costs**

Most of the interviewees identified the direct non-medical costs incurred by society in response to child maltreatment. These costs are professional services provided by social workers, police and the courts for the purpose of investigating reported child maltreatment. They identified provision of infrastructure, human resources and social assistance for children who are found to be at risk of maltreatment or whose maltreatment is substantiated. They indicated that the service system was burdened by the need to finance alternative care services and transfer of foster grants.

For example, one key informant stated the far-reaching costs as follows:

*“Professional services, police, justice, social work, education, trauma services, social grants, homes, costs to parents who are affected economically and are under strain.”*

#### **4.2.5 Indirect costs**

Similarly, several interviewees recognised the indirect societal costs of child maltreatment in the form of future economic and development loss. Many key informants emphasised both immediate and long-term economic consequences of child maltreatment for society. For example, society incurred productivity loss due to a generation that requires extraordinarily high educational resources and has a low ability to find jobs due to psychological and developmental impacts of maltreatment. The situation leads to society having “dysfunctional generations” of violent and unemployable people who depend on the state and other members of society for their welfare. As one of the key informants stated:

*“There are many costs involved along the route of a child who has been abused, but the major one is the long-term impact on the economy as this may result in people who are dysfunctional and unable to contribute to society or take care of themselves”.*

The situation was seen as exacerbated by a lack of effective interventions that could effectively break the cycle of maltreatment. As another interviewee stated:

*“A lack of both preventive and responsive interventions enables the continuation of abuse across generations and this has long-term economic implications”.*

Other societal costs identified were low social cohesion due to a weak moral fibre in the affected communities leading to many people who live in unsafe environments and have low trust. As one of the key informants stated:

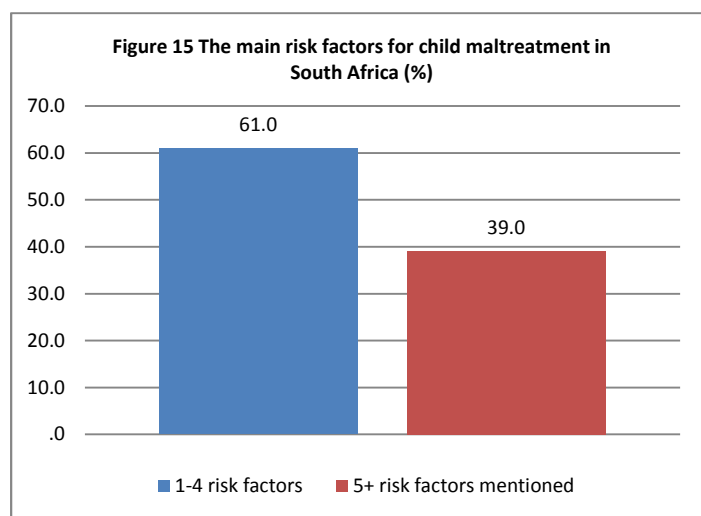
*“Yes, there are system and structural costs as a result of the services that are being used. But the main costs are the psychosocial costs for the country: intellectual development, personal dignity, happiness, sense of security – all of these have an overall cost on the moral fibre and economy of the country”.*

In general, interviewees showed less awareness about the medical costs of child maltreatment. They did not identify the link between child maltreatment and chronic health conditions. A lack of

responses in relation to health consequences could also be due to the under-representation of health professionals in the sample. It could also reflect lack of awareness about the international literature on the link between health and child maltreatment as well as limited research focus on the subject locally.

#### 4.2.6 Knowledge about risk factors

Majority of interviewees (61%) identified between 1 and 4 risk factors for child maltreatment in South Africa while 39% of interviewees stated 5 or more risk factors (Figure 15).



#### *Individual level risk factors (parent- or care-taker related)*

Interviewees identified risk factors at individual level and all the risk factors were in relation to a parent or caregiver; none of the interviewees identified individual risk factors related to a child.

- *Having been maltreated as a child*

They mentioned generational and inheritance of trauma; adults who have unresolved trauma and belonging issues as the main risk factors.

- *Lacking awareness of child development or having unrealistic expectations*

Poor parenting skills

Lack of information, ignorance about basic child care

Poor education and lack of parenting skills

- *Misusing alcohol or drugs, including during pregnancy*

The majority of interviewees identified alcohol and drug abuse as a major risk factors for child maltreatment.

- *Being depressed or exhibiting feelings of low self-esteem or inadequacy*
- Personal make-up in terms of people lacking self-value,
- lack of positive role models and lack of parental skills;
- Lack of sense of purpose
- *Experiencing financial difficulties*  
Parental stress, unemployment  
teenage pregnancies

### ***Family breakdown or violence***

- Dysfunctional families,
- Lack of parental responsibility
- Breakdown in family structure – decline in moral values.
- Attitudes of men towards fathering and family responsibility
- Single parenthood: children are often abused by step parents or partners of their single parents

### ***Being isolated in the community or lacking a support network***

- Communities not involved
- weak social support networks in poor communities
- Dysfunctional communities
- Lack of cohesion in communities
- Lack of common trust in communities, disintegration of social values
- Mistrust in communities

### ***Breakdown of support in child rearing from the extended family***

- Child-headed households;
- Households in rural areas are very vulnerable



## ***Community level risk factors***

### *Tolerance of violence*

- High levels of societal violence in SA generally, both in public and private arenas,
- Gangsters

### *Gender and social inequality*

- Effects of apartheid, unemployment.
- Poverty, unemployment, Poor households, unemployment,
- Gender issue in terms of how women are viewed in society
- 'Dop' system<sup>2</sup> on farms, alcohol abuse, overcrowding

### *Lack of adequate housing or services to support families and institutions*

- Stress factors related to poor living conditions
- Lack of support services for families,
- Overcrowding

### *High levels of unemployment or poverty*

- Stressed families due to poverty, inadequate coping mechanisms, and support systems;
- Poverty-related challenges

## ***Societal level***

### *Inadequate policies and programmes to prevent child maltreatment, child pornography, child prostitution and child labour*

- A weak child protection system that fails the child
- Lack of focus on relationships and communication skills in all spheres of a child's development
- The lack of preparation for parenthood
- Not informed enough about where to seek assistance
- low rate of prosecution
- Lack of social support for young parents

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<sup>2</sup> An outlawed method of paying labourers on farms with cheap liquor, it is mainly believed to be practised in the Western Cape Province.

Social and cultural norms that promote or glorify violence towards others, demand rigid gender roles, or diminish the status of the child in parent–child relationships

- Learnt behaviour
- Broken values in society;
- A sense of cultural unity which sustains abuse – also these social norms are impacted upon by the media

*Social, economic, health and education policies that lead to poor living standards, or to socioeconomic inequality or instability*

- Socio-economic issues, parental stress, unemployment,
- Disempowerment of people

The key informants recognised the risk factors for child maltreatment at societal, community, family and relationship levels. However, they did not mention child-related risk factors in a parent-child relationship. Conception and pregnancy outcomes in South Africa can be the result of different circumstances that include child sexual abuse, gender-based, intimate partner violence and poor maternal health care leading to problematic parent-child relationships. The ability of health providers and social workers to recognise and identify such risks would benefit the child to realise their right to survival, health and protection.

#### ***4.2.7 Knowledge about the appropriateness of the different types of interventions***

When asked about the appropriateness of the different types of interventions for preventing child maltreatment, the vast majority of interviewees characterised *early home visitation* (80.5%) as extremely appropriate ; *parenting education* was perceived as extremely appropriate by 78% of the interviewees; *child sexual abuse prevention* interventions were considered extremely appropriate by 52% of the interviewees; and *prevention of abusive head trauma* was found to be extremely appropriate by only 40% of interviewees.

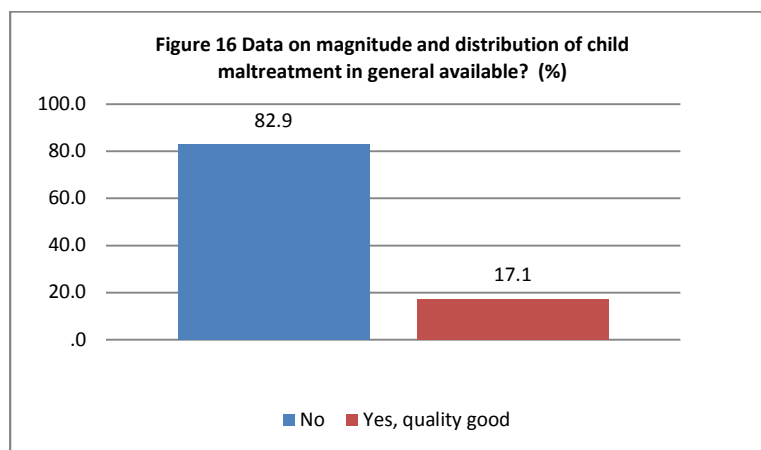
Both early home visitation and parenting education programmes are not available at population level in the country. This is despite the widely held view among researchers in this field that South African children and families would have health, nutrition, safety and protection benefit from programmes that entail antenatal care services and a professional or community worker visiting families with children from early in the life of the child (see an interview with Professor Andy Dawes by Paul McNally: [www.nn.co.za](http://www.nn.co.za)). A couple of models based on the philosophy of integrating child development and maternal mental health needs into primary health care services for mothers show the worth of such interventions in diagnosing problems early and facilitating intervention through appropriate services that improve child outcomes (Hartley, Tomlinson et al, 2011; Honikman, van Heyningen et al, 2012).

### 4.3 Dimension 3: Existence of scientific data on child maltreatment and its prevention

This dimension assessed the key informants' views about the availability of different types of child maltreatment data, and examined the situation of child maltreatment prevention data in terms of reporting mechanisms and procedures as well as information systems in place.

#### 4.3.1 Child maltreatment data availability

The majority of the respondents (83%) stated that data regarding the general magnitude of child maltreatment was not available. There was no difference between national key informants and provincial informants in this regard (Figure 16).

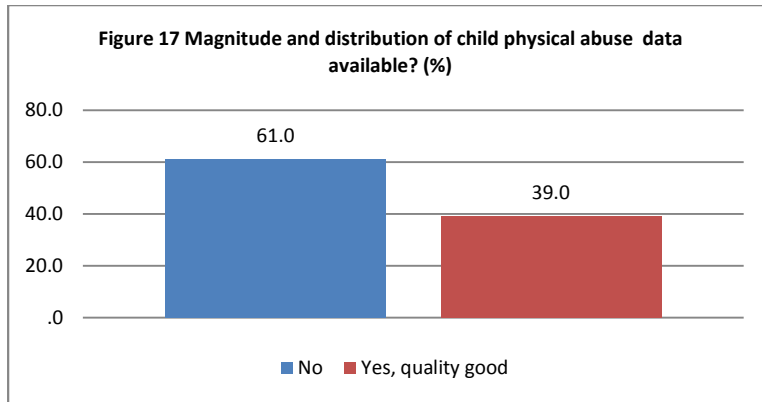


Most key informants emphasised that data was not available. Although some indicated that generally in the Western Cape Province provincial data was obtainable, the limitation was that data was primarily based on reported cases and was not representative of the populations in each province. For example, one stated that *“pockets of data exist, but are not reliable”*. They specifically pointed to the challenges that the country faces in relation to planning, programme implementation and evaluation due to lack of surveillance data.

#### 4.3.2 Availability of data on the different types of child maltreatment

##### a) Child physical abuse

Most of the key informants (61%) indicated that data on the magnitude and distribution of child physical abuse did not exist compared to 39% who stated that such data was available (Figure 17). Provincial interviewees were more likely to report availability of physical abuse data (44%) than national interviewees (31%). Some of the key informants referred to availability of hospital records which they said could be analysed to assess the magnitude of child physical abuse.



Some of the key informants referred to availability of hospital records which they said could be analysed to assess the magnitude of child physical abuse. Other sources on incidence data are child protection agencies, education authorities and schools. These provide an indication of the extent to which children are affected by corporal punishment in schools, despite it being outlawed, and at home.

A recent review by the South African Human Rights Commission and UNICEF(2011) reports on Statistics South Africa data which confirms earlier findings (Dawes, De Sas Kropiwnicki, et al 2005) that harsh punishment of children is commonplace in South African families.

#### *b) Child sexual abuse*

About two-thirds of the key informants (61%) indicated that data on the magnitude and distribution of child sexual abuse was not available compared with just about 39% who said the data was available.

Those who specified the sources of data for child sexual abuse mentioned the Medical Research Council study which was conducted in 2003. The study published reports of rape and attempted rape of children to South African Police Services in all nine provinces for 2000. There were 52,599 cases of rape and attempted rape of women; 21, 438 cases were of children under the age of 18 years; of which about 8000 (37%) were of children under the age of 12 years (with 7 to 11 years mostly affected). There were also 2,934 cases of indecent assault of men of which 1,627 cases (55%) were children. However, sexual offences against males were considered under-reported.

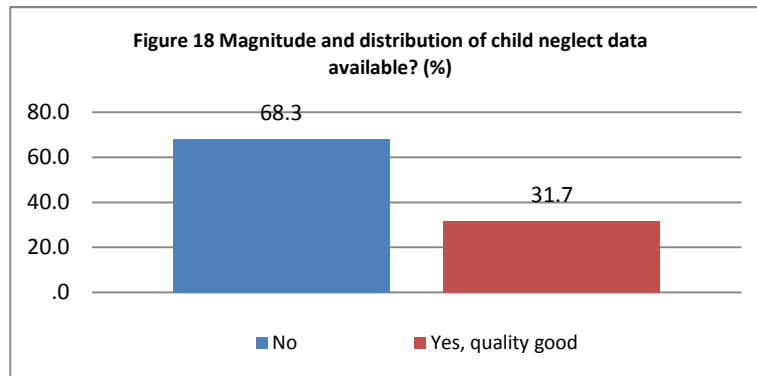
South African Police Services crime reporting statistics have improved over the years and crimes against children and women have become prominent in the policing agenda. These statistics indicate that nationally sexual offences committed against children increased from 25 428 in 2006/07 to 27 417 in 2009/2010 (South African Human Rights Commission and UNICEF, 2011). Clearly these reports do not include cases for which investigations did not lead to successful conviction, indicating that child protection agencies data is critical.

#### *c) Child psychological and emotional abuse*

Almost all key informants, except one, stated that there was no data available at national and provincial levels on the magnitude and distribution of child psychological and emotional abuse in South Africa. Other studies have reported that although child care practitioners generally believe that child psychological and emotional abuse was commonly experienced by children, it was the most difficult form of abuse to substantiate and document (Makoae et al, 2009b).

#### d) Child neglect

Majority of interviewees (68%) stated that data on the magnitude and distribution of child neglect was not available (Figure 18). Some interviewees indicated that data was available on reported cases only, while data on general neglect at community level was not available. Data gaps occurred because the public did not know where to report incidents of neglect they observe in the communities. There was a concern that the public was not provided with information on availability of resources and support.



#### 4.3.3 Availability of data on short and long-term consequences of child maltreatment

Majority of the respondents (75.6%) stated that there was no data on both short-term and life-long consequences of any forms of child maltreatment in the country. About 20% of the respondents stated that they did not know if the data existed. Some suggested that the foster care database could provide valuable information on long-term consequences of child maltreatment.

Child maltreatment consequences vary from the most immediate such as physical injury to long-term developmental and social functioning impairments for victims. In South Africa there is a lack of systematic studies that document the consequences of child maltreatment. According to the interviewees, the situation is more serious for child psychological or emotional abuse than for child physical abuse, child sexual abuse and child neglect. This could be because the three forms of child maltreatment present comparatively less difficulties for social workers and police to investigate and substantiate than psychological abuse. The commonly documented consequences of child maltreatment are physical injuries treated in hospital trauma units following physical and sexual abuse (Dawes et al, 2006). This is only the tip of the iceberg as many cases perceived as less severe may not be treated in hospital, or if fatal are captured in mortality data, and sometimes child maltreatment is not specified as a cause of death. Stephen, Patrick et al (2006) report severe under-reporting of child deaths attributable to child maltreatment in South African paediatric wards. In 2011 the reporting situation had not improved, but there is evidence that between 2005 and 2009, there were 68 (0.3%) of hospital child deaths due to non-accidental injury, abuse-related, neglect and homicide (Stephen, Bamford, Patrick & Wittenberg, 2011). Other information gaps in child protection data in the country include the extent of child sexual abuse outcomes such as adolescent pregnancy and paediatric HIV infections.

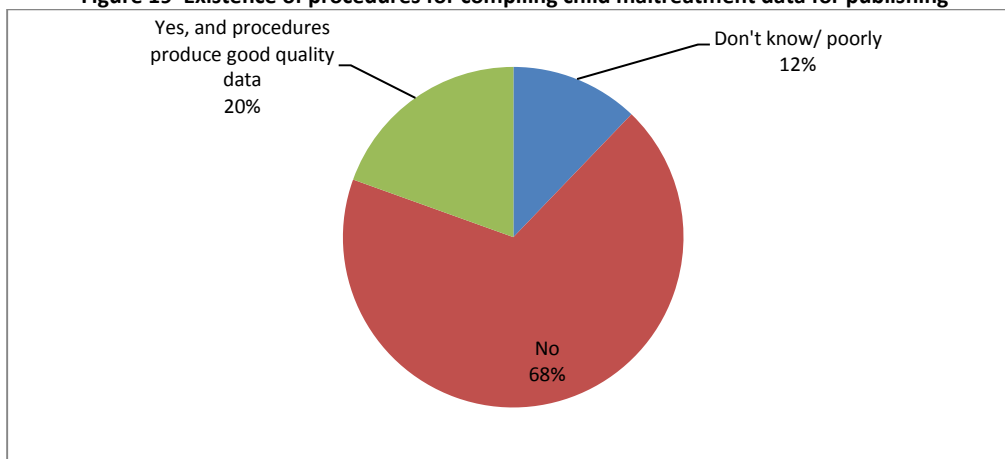
Poor data availability is an indication of underreporting and information systems that are not sensitive enough to capture certain forms of information.

#### 4.3.4 Child maltreatment reporting and information systems

The majority of key informants (85%) indicated that the country has a system for official definitions of child maltreatment and 93% stated that the reporting of child abuse, neglect and exploitation was mandatory (under the Children’s Act). However, about 68% of the respondents indicated that the existing reporting system was working poorly compared with 29% who said the system worked fairly well and 3% who said it worked well.

Clearly, there are inadequacies when it comes to the process of compiling child maltreatment data for regular publishing in the country. Only 20% of interviewees assessed the procedures for compiling child maltreatment to produce good quality data. Majority of interviewees stated that such procedures did not exist (Figure 19). The South Africa Child Protection Surveillance Study has the enhancement of data management as one of its goals. The study is expected to develop and recommend an implementation framework for compiling child maltreatment data emanating from different agencies. It will support “the identification, assessment and reporting of child abuse cases on the child protection register” (Department of Social Development, 2011).

**Figure 19 Existence of procedures for compiling child maltreatment data for publishing**

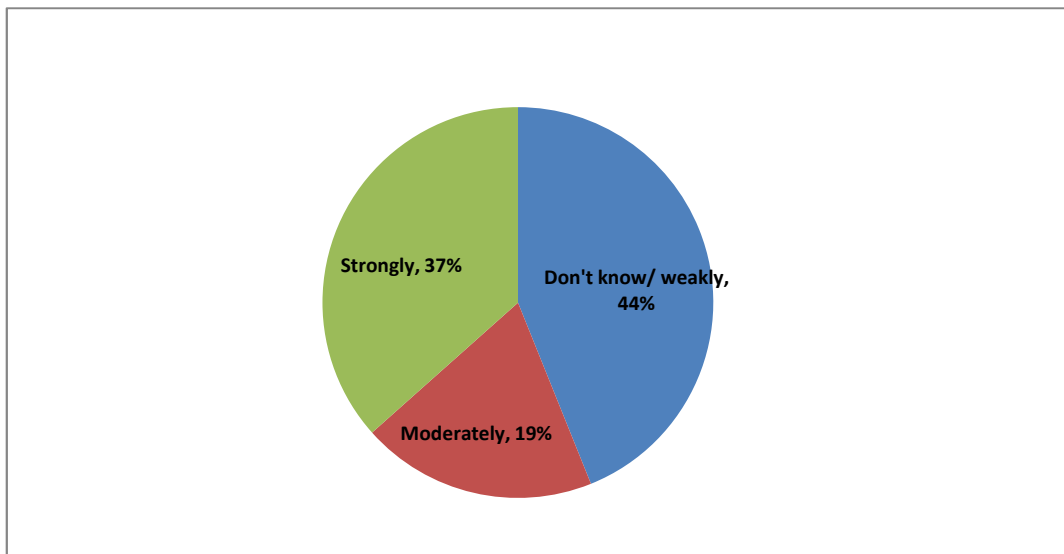


Interviewees indicated that although there were procedures in place for compiling child maltreatment data, they were not consistently utilised. For example, the Child Protection register was currently not working properly. Government departments often do not provide annual reports of child maltreatment cases known to them. Similarly, some agencies captured data consistently but there was no system for analysing the data. Part of the system includes reports on the child protection register given quarterly at the National child care and protection forums and included in Social Development annual reports. The situation has implications for planning, implementation and evaluation of services.

More than two-fifths of interviewees (44%) stated that scientific evidence influenced the thinking and decisions in policy, law making and implementation weakly. About 37% of the key informants stated that scientific data influenced decisions about child

maltreatment prevention strongly. About 19% of them said data influenced decisions moderately (Figure 20). Most of the interviewees in the Western Cape Province (48%) were more likely to state that scientific evidence influenced decision making about child maltreatment prevention than were national interviewees (18.8%).

**Figure 20 How much scientific data on child maltreatment and its prevention shapes the thinking and decisions in CMP**



Some of the interviewees indicated that the importance of evidence base for child protection responses was only recently recognized. And while it was used consistently to shape the post-apartheid policy and legislation, it was still not used in relation to programme planning. One of the interviewees stated:

*“A real attempt was made when developing the Children’s Act, Child Justice and Sexual Offences Act to base recommended provisions on research and in some instances specific pieces of research were commissioned – however the final decisions are made by politicians who usually do not read the research and discard this information – this happened frequently in the law reform process” (National Key Informant).*

The barrier was identified as lack of national studies; decisions were overly based on desk top reviews and what was happening in provinces. South Africa has not conducted a nationally representative population-based studies on the prevalence of child maltreatment. Agency-based incidence data collection on child maltreatment is characterised by several short-comings that include shortage of human resources. Most reports used to estimate the extent of child maltreatment are crime statistics published by the police services annually.

The majority of key informants 84.5% indicated that South Africa had official definitions used to record the incidence of child maltreatment. The majority of interviewees knew that the Children’s Act provided the definitions. In theory, the reporting system consists of the Child Protection Register that is supposed to be implemented by child protection agencies and maintained by the Department of Social Development. The law mandates various categories of professionals to report child abuse to designated child protection organisations (NGOs mandated to provide statutory services), police office or the Department of Social Development. There were concerns that the system was not well maintained and monitored to provide reliable data and that there was general under-

reporting by different child protection agencies. This could be seen as a factor for explain over dependence on crime-derived data from the police and less on child protection agencies. Part of the reason was that although there were official definitions of child maltreatment, not all sectors that received reports or see children who are affected by child maltreatment used similar definitions. For example, Dawes et al (2006) reported discrepancies in administrative data collected by police and health institutions in relation to categorisation of cases according to age – a child was differently defined. As a result cases of children aged above 13 years may not be captured under children’s data, thus leading to under-estimation of the problem.

Key informants indicated that the mandatory reporting system for professionals is detailed out in the Children’s Act but that professionals do not adhere to procedures. Other shortcomings in the system were attributed to the law itself and reporting agencies. The Children’s Act and its regulations make it mandatory for professionals and various categories of child workers to report child maltreatment to police, designated child protection organisations and provincial departments of social development. The main concern was that most professionals perceived the form, which should be the main source of data from administrative records kept in hospitals and health care facilities (Form 22) to be complex. The system largely depends on a manual capturing of information using the Form 22 and it is not working well.

Although electronic systems were in place, most key informants thought the systems were managed poorly or used inconsistently due to high staff turn-over in non-governmental child welfare agencies. Interviewees identified other factors that undermined the effectiveness of the system as low literacy and numeracy levels, and lack of capacity among staff which often made it difficult for the correct information to be recorded, emphasising the need for supervision. Some responses suggested that some agencies and departments applied definitions and reporting requirements on an ad hoc basis.

#### **4.4 Dimension 4: Current programmes implementation and evaluation**

Interviewees were asked to state any child maltreatment prevention programmes that were currently being implemented or were implemented in the past. They were also asked to specify the type of programmes they identified, whether the programmes were implemented at national, provincial or community levels, and whether programmes had undergone an outcome evaluation.

Currently programme implementation for child maltreatment prevention is low. However, there are opportunities to expand services that improve the wellbeing of children including those who are highly vulnerable. Mainly through child care programmes that the state in partnership with NGOs have implemented country-wide to provide services for children at risk due to high prevalence of HIV and AIDS chronic illness of adults (parents and caregivers), many children at risk are identified and supported through cash transfers and psychosocial services. Programme outcome evaluation is poor even for most of the programmes working in the HIV and AIDS field. In many instances, the programmes are implemented through donor funding and there is more interest in the implementation process and monitoring strategies are in place for purposes of accountability.

##### ***4.4.1 Programmes currently being implemented or have been implemented in the past***



About 71% of the interviewees stated that they knew child maltreatment prevention programmes that were currently being implemented while 27% did not know about such programmes. Similarly, 71% of interviewees were able to name at least one child maltreatment prevention programme (Table 5). For each programme identified, most of the interviewees were not able to specify the type of the programmes, while most of the programmes were identified as implemented at provincial level.

On average, only about one third (32%) of the interviewees who identified between 1 and 5 programmes were able to specify the type of programme each was.

On average, 28% of the interviewees who identified between 1 and 5 programmes stated that the programmes were implemented at provincial level. This is compared with only 15.6% of interviewees who identified programmes implemented at national level.

Only 6 of the 29 interviewees (21%) who stated between 1 and 5 programmes could say that the mentioned programmes underwent outcome evaluation.

Only 6 of the 41 interviewees (14.6%) could identify programmes that were not particularly aimed at preventing child maltreatment but into which child maltreatment prevention components could be integrated. But only 3 of the 6 could specify the type of programme these were.

The majority of interviewees could not say whether or not the programmes were ever evaluated, while a few who knew the status of the stated projects reported that they were never evaluated. There have been recommendations to develop indicators of performance for social development programmes geared towards child and family welfare (Lund Committee, 1996) and attempts have been made to develop indicators for various child outcomes including child health and protection (Dawes et al, 2007). The professionalization of programme monitoring and evaluation has permeated most institutions, and the child sector is still to systematise impact evaluation of interventions.

Although several different child maltreatment prevention programmes were identified, most of them had limited coverage and were implemented by organisations with specific goals. Government and civil society needed to work together, and with the same level of commitment as in the HIV and AIDS field, implementing programmes for primary prevention of child maltreatment taking into account the variety of risk factors for child maltreatment affecting families is crucial. Child wellbeing and development are safeguarded through supportive family relationships and meeting the basic needs and it is important to address both aspects.

Table 5 Programmes identified by key informants

Name of the programme	Frequency
Anti-bullying campaigns	2
Champion for children	2
Parenting programme/Positive parenting	11
Child Protection Month	6
Community Dialogues	3
DICAG/others' awareness of abuse workshops	3
Early childhood development	8
Eye on the child	5
Family preservation/ strengthening	6
Parent-infant/child Home visitation	6
Community Workers training: psychosocial support at health clinics; perinatal mental health; postnatal depression	5
16 Days of Activism	1
Family Expo	4
Child at risk/holiday/sport recreation	3
Child health & schools: vaccines, nutrition & feeding schemes	3
UNICEF GEM/BEM, safety and crime prevention at schools	2
Leadership programmes	2
Isibindi (NACCW), Community child protection	2
Centre for Justice & Crime Prevention	1
Brother for life	
Loveline	1
NICRO Diversion	1
Quaker Peace	1

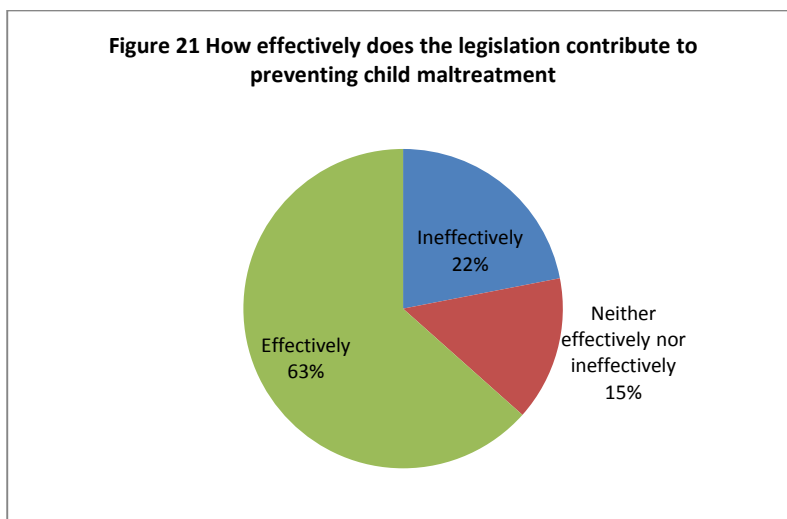
Table 6: Current/past CMP programmes with CMP component or potential to have CMP component

Name of the programme	Features
Anti-bullying campaigns	Potential CMP
Champion for children	Actual CMP
Parenting programme/Positive parenting	Actual CMP
Child Protection Month	Actual CMP
Community Dialogues	Potential CMP
DICAG/others' awareness of abuse workshops	Actual CMP
Early childhood development	Actual CMP
Eye on the child	Actual CMP
Family preservation/ strengthening	Both
Parent-infant/child Home visitation	Actual CMP
Community Workers training: psychosocial support at health clinics; perinatal mental health; postnatal depression	Actual CMP
16 Days of Activism	Potential CMP
Family Expo	Actual CMP
Child at risk/holiday/sport recreation	Potential CMP
Child health & schools: vaccines, nutrition & feeding schemes	Potential CMP
UNICEF GEM/BEM, safety and crime prevention at schools	Potential CMP
Leadership programmes	Not clear
Isibindi programme	Actual CMP
Centre for Justice & Crime Prevention	Potential
Brother for life	Potential CMP
Loveliflife	Unclear
NICRO Diversion	Potential CMP
Quaker Peace	Actual CMP

The low score for availability of CMP programmes and programmes in the country or in the Western Cape Province into which CMP components could be integrated and their outcome evaluation (Dimension 4) the score showed that some of the key informants were unable to name child maltreatment programmes including those that were not explicitly aimed at preventing CM but into which CMP components could be integrated. They mainly include child, maternal and family programmes in the health sector. CMP programmes are inadequate in the country and in the Western Cape Province, as most NGO that provide child services focus on early childhood development, early intervention and child protection based on investigation outcomes. The major gap in these services is that they are not mostly child-oriented and do not work with parents to enhance their parenting skills and help them overcome key family-based challenges such as alcohol abuse or domestic violence during pregnancy. They focus on the rights of the child without assisting parents who are at risk to strengthen their protective capacity. Government needs to maximise the benefits of high utilisation of maternal and child health care services by integrating and evaluating CMP services in the already successful programmes. Community development services and community workers as well have the potential to provide the needed support to families with children, and CMP programmes do not have to depend on social work professionals who are already overwhelmed by high case-load involving child protection issues.

## 4.5 Dimension 5: Legislation, policy and mandates

Majority of the interviewees (63%) stated that the legislation was effective in contributing to child maltreatment prevention. About one-fifth (22%) of the respondents found legislation to be ineffective, while about 15% of interviewees described the legislation as neither effective nor ineffective in preventing child maltreatment (Figure 21).



The qualitative responses highlighted that the country was in transition from a legislation that supported statutory interventions to implementation of prevention and early intervention programmes. As many key informants indicated, it was too soon to evaluate the impact of the newly enacted law:

*“The legislation only came into effect last year(2010) and provincial systems are not yet harmonized in terms of the systems that are required. It is too early to make an assessment” (Key Informant, Provincial)*

*“The effectiveness of the law has not been tested yet as the Act has been in force for less than a year and is currently being rolled out” (Key Informant, Provincial).*

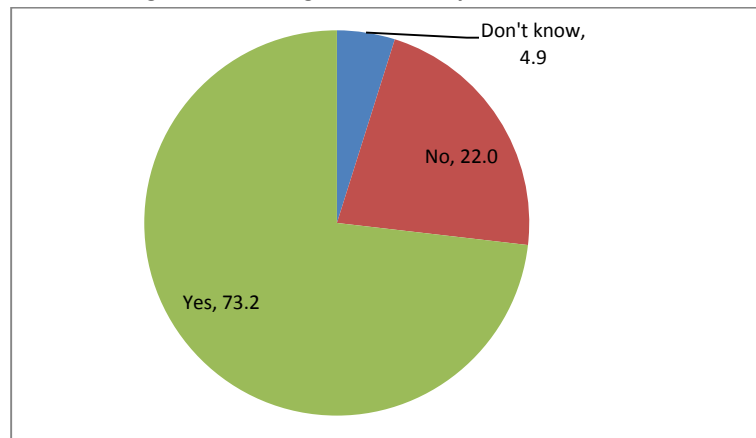
*“Children’s Act makes prevention mandatory, but impact of legislation not yet measured” (Key Informant, National).*

Key informants generally stated that it would be premature to assess the effectiveness of the new law towards preventing child maltreatment as this was a new focus in South Africa. A clear milestone thus far is the establishment of structures and processes necessary to implement the law. However, some observed that although the Act mandates provincial Ministers of Social Development to implement prevention programmes, it was not prescriptive in terms of how prevention should be done. The lack of detail is a concern as it could lead to a lapse of time before tangible programmes are implemented. It is a long time since the White Paper for Social Welfare was developed yet there is still a lack of prevention programmes.

#### 4.5.1 Agencies mandated with the prevention of child maltreatment

Most participants (73%) agreed that the law mandated certain agencies to prevent child maltreatment (Figure 22). Most interviewees identified the national and provincial departments of Social Development as lead agencies, but also mentioned government departments stated in the Children's Act (health, education, justice and local government). They indicated that in practice the bulk of services were provided by NGOs mandated by the Department of Social Development to provide services. Some of the NGOs have national mandates while others limit their activities to the provincial level.

Figure 22 Are any government or non-governmental agencies officially mandated with child maltreatment prevention?



However, it was only a few organisations involved in prevention compared to those that provide statutory services. The Social Development department has devolved the responsibility to do prevention work to NGOs, an arrangement which some key informants criticised limiting the effectiveness of interventions.

For example, one key informant stated:

*“A number of government departments and NGOs are mandated to do child abuse prevention work. However they may also have response responsibilities as well – and perhaps one could view prevention-response as a continuum in the child protection field. Government departments include inter alia – Department of Social Development, considered the lead Department in prevention and response, health, education; and numerous NGOs – Childline, Child Welfare, etc.” (Key Informant, National).*

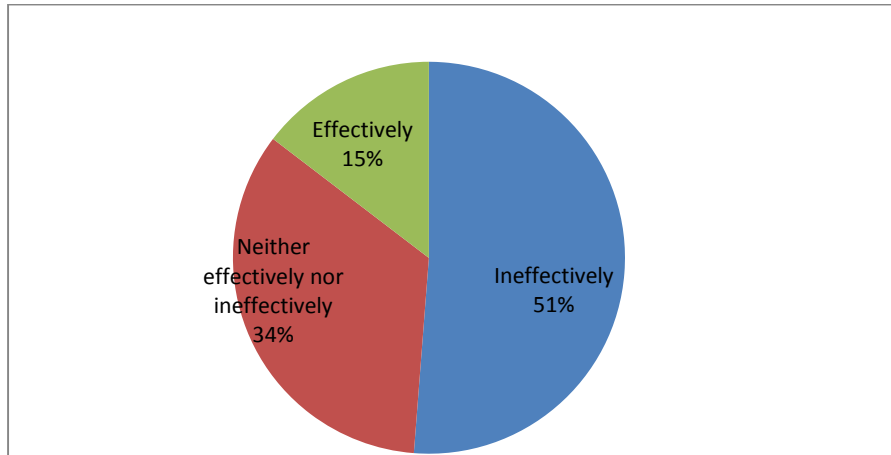
Majority of interviewees (51%) stated that the mandated organisations were effective in preventing child maltreatment. Only 15% stated that the agencies were effective compared with 34.4% who said the agencies were neither effective nor ineffective (Figure 23).

The effectiveness of government and non-governmental agencies working in this field was said to be primarily hampered by persisting focus on statutory services and lack of resources. Interviewees indicated that prevention is either not resourced appropriately or adequately. Some of the national key informants stated that there were disparities between provinces in terms of resource availability and that provinces with high budgets for child protection had functioning interventions. Nevertheless, the bulk of resources are allocated for response measures during emergency situations. Both highly qualified professionals and finances are committed to

statutory care services (investigation, for children and families already affected by child maltreatment. The following interviewee sums it:

*“They do mostly statutory intervention work which uses all their resources, so very little goes towards prevention” (Key Informant, Provincial)*

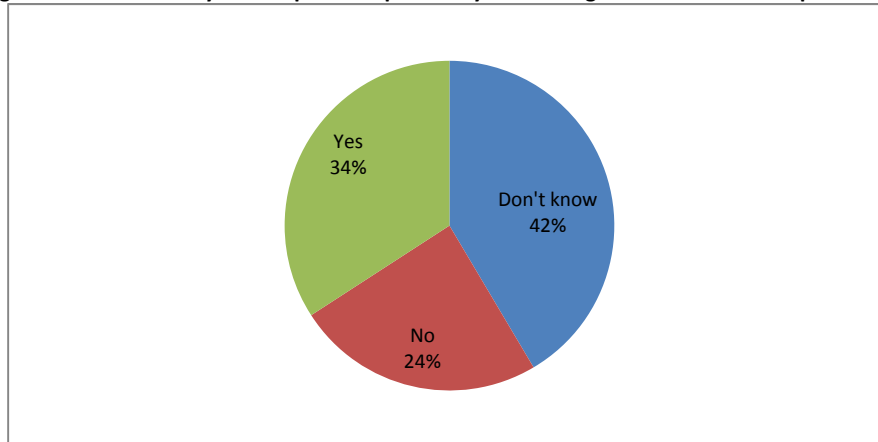
**Figure 23 How effectively do these mandated organisations contribute to preventing child maltreatment?**



#### **4.5.2 Official policies specifically addressing child maltreatment prevention**

More than 40% of the key informants did not know whether or not there were official policies addressing child maltreatment prevention. Only about one third (34%) of key informants agreed that there were official policies specifically addressing child maltreatment prevention (Figure 24).

**Figure 24 Are there any official policies specifically addressing child maltreatment prevention?**



Only 10 of the interviewees provided information regarding the effectiveness of existing official policies on child maltreatment prevention. Interviewees referred to official documents such as the *National Policy and Strategy on the Prevention and Management of Child abuse, Neglect and Exploitation, 2004* (at national level) and the provincial level participants referred to “An

*Integrated Care and Protection Plan for Children in the Western Cape (2007)*. They also mentioned that the process of reviewing the policies was underway. The participants who were of the view that a policy document did not exist specifically referred to the lack of focus on child maltreatment prevention in the existing policies, a situation which was being rectified by the revision processes. The review of the Plan is primarily necessitated by the new Children’s Act.

**4.5.3 National policies**

The principal legislation for the prevention of child maltreatment is the Children’s Act (No. 38 of 2005, as amended) and its Regulations. All interviewees identified the Act as key because it includes a whole section (Chapter 8) authorizing the Department of Social Development at provincial level to finance and implement prevention programmes for children. It further provides for the establishment of two Child Protection Registers, one for registering children who have been found to be in need of care; and the second register for people who have been found guilty of committing crimes against children. Other laws with a preventive effect are the Social Assistance Act (2005) and the Domestic Violence Act.

**a) The National White Paper on Social Welfare (1997)**

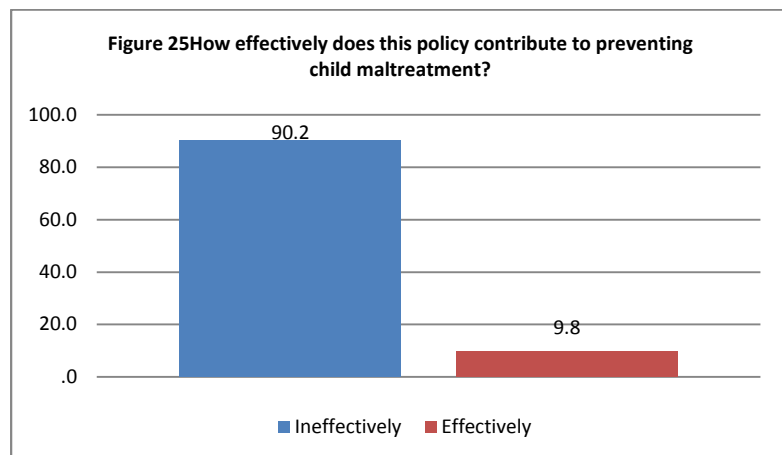
The National Policy and Strategy on the Prevention and Management of child abuse, neglect and exploitation (2004) The National Policy Framework and Strategic Plan for the Prevention and Management of Child Abuse, Neglect and Exploitation (2004) was developed to guide the country response to the problem of child abuse, neglect and exploitation. It aims to reduce the incidence of child abuse, neglect and exploitation; and ensure the effective management of cases of abuse, neglect and exploitation. It provides guidelines for an integrated and collaborative service delivery by government and civil society.

In addition, a few national interviewees referred to the National Child Protection Strategy (2000) which they viewed as having inclusive provisions relating to child abuse or maltreatment prevention in an integrated manner.

**b) Provincial policies**

The Provincial Care and Child Protection Strategy which includes prevention and was under revision to enhance prevention aspects.

Almost all interviewees considered the existing policies to be ineffective in preventing child maltreatment (Figure 25).



Interviewees identified excessive focus on responsive and statutory services and serious budgetary constraints as important factors affecting effective implementation of policy for preventing child maltreatment. Additionally, most of the interviewees argued that policies to address child maltreatment prevention were recently initiated and that more time was needed before their effectiveness could be reasonably determined. The effectiveness of policy was reported as limited to a large extent by inappropriate implementation and poor resourcing of programmes.

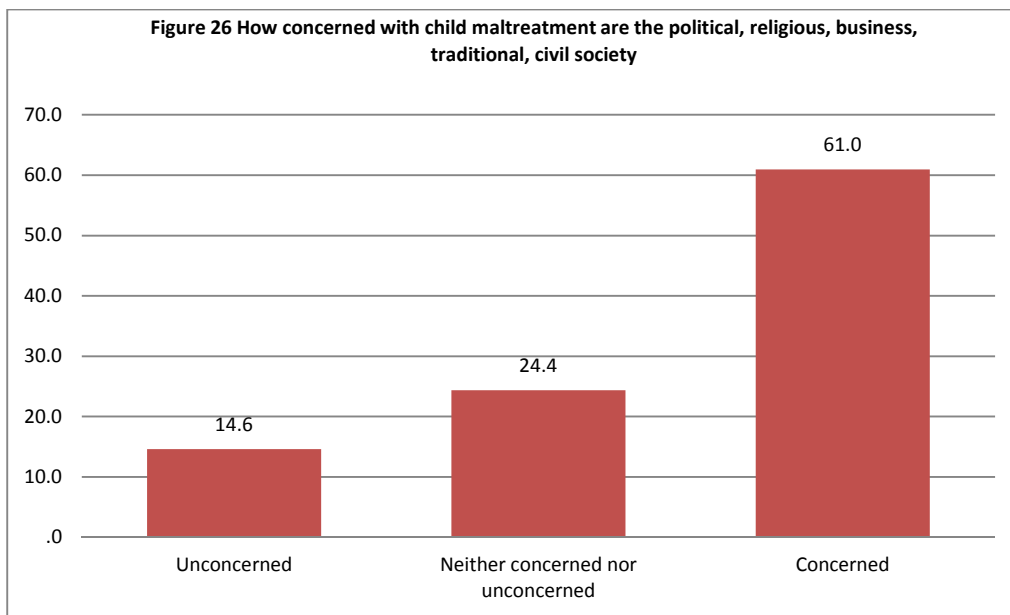
It is important to be critical of the view that the key legislative framework was recently adopted. The evolution of the social welfare policy since the adoption of the Constitution in 1996 provided ample opportunity for role players to implement effective prevention programmes, especially because the vision and philosophy of the new government was unambiguously developmental.

#### 4.6 Dimension 6: Will to address problem

The strength of the will to address child maltreatment prevention in South Africa is gauged by assessing five different facets of this construct: leadership, political will, public will, advocacy, and communication.

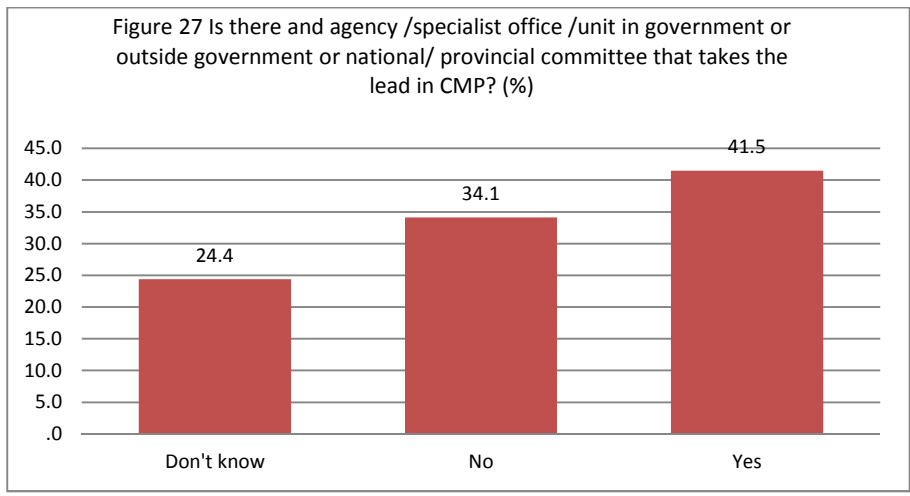
##### 4.6.1 Leadership

The key informants were asked about their opinion regarding how concerned, overall, the various leadership in society such as religious, political, business and civil society were concerned with child maltreatment. The majority of interviewees (61%) perceived the general leadership to be concerned with the problem of child maltreatment while only about 15% said the leadership were not concerned; and 24% said the leadership were neither concerned nor unconcerned (Figure 26). In most instances, the interviewees referred to political leaders in particular because other categories of leaders were not viewed as vocal.





The interviewees were uncertain about whether or not South Africa has an agency that took lead in child maltreatment prevention. Even some of those who stated that such an entity existed, were uncertain. About 40% stated that there was an agency, a unit in government or a committee with this role. About 34% said such a structure did not exist while 24% did not know if it existed or not (Figure 27).



National and provincial key informants' responses showed significant differences in perception with about 69% of national key informants compared with 24% of provincial informants agreeing that such agencies existed. The majority of provincial respondents (52%) respectively said such agencies did not exist (Table 7).

**Table 7 Agency, specialist office or unit that takes the lead in child maltreatment prevention by whether national or provincial interviewee**

		Whether national or provincial interviewee		Total
		national	WC Province	
Any agency, specialist office or unit that takes the lead in child maltreatment prevention	Yes	11 68.8%	6 24.0%	17 41.5%
	No	1 6.3%	13 52.0%	14 34.1%
	don't know	4 25.0%	6 24.0%	10 24.4%
Total		16 100.0%	25 100.0%	41 100.0%

Participants mentioned different structures both in government as well as those that involved partnerships between the state and civil society. The following structures were specified:

The Child Protection Directorate within the national Department of Social Development

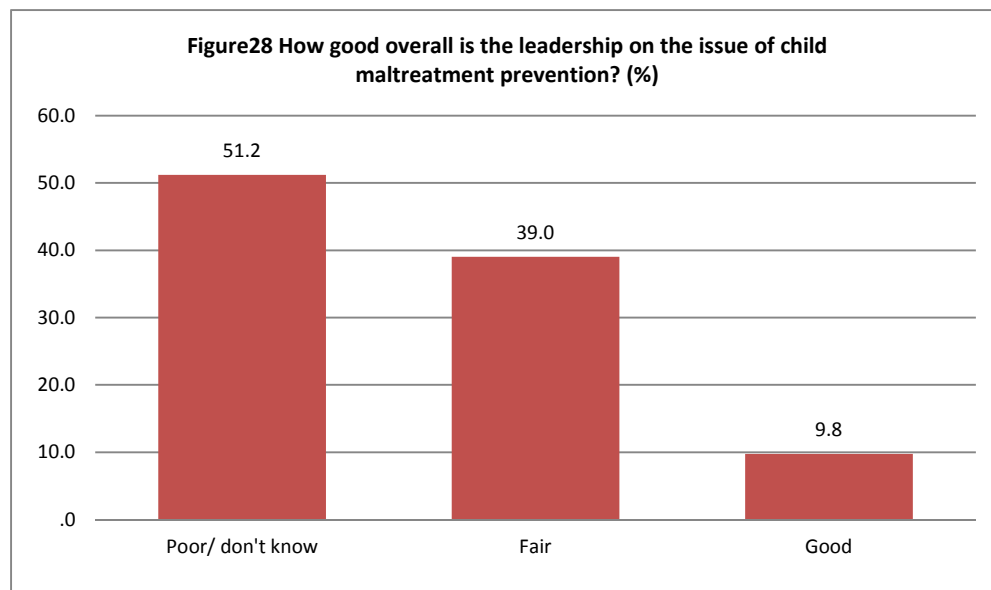
The non-operational Office on the Rights of the Child (ORC) which still exists within the Presidency.

The newly established Department of Women, Children and People with Disabilities.

Most of the interviewees identified the National Child Care and Protection Forum and Provincial Child Protection Committees.

It was interesting that in many instances, officials working for some of the agencies which others recognised as taking the lead in child maltreatment prevention did not associate the role with their organisations as they identified different entities as well.

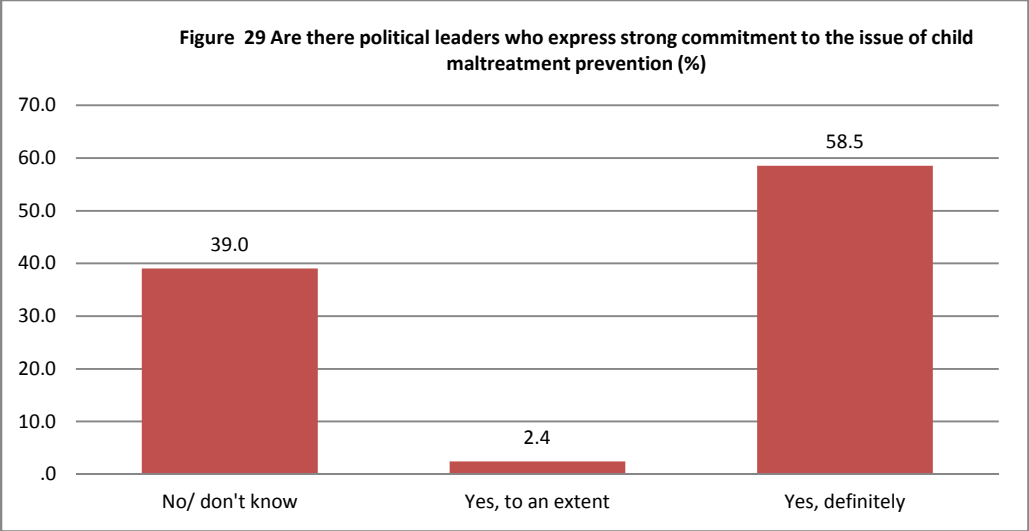
Most interviewees (51%) perceived leadership on the issue of child maltreatment prevention to be poor compared with just about 10% who believed the leadership was good and some 39% of interviewees believed that leadership on the issue was fair (Figure 28).



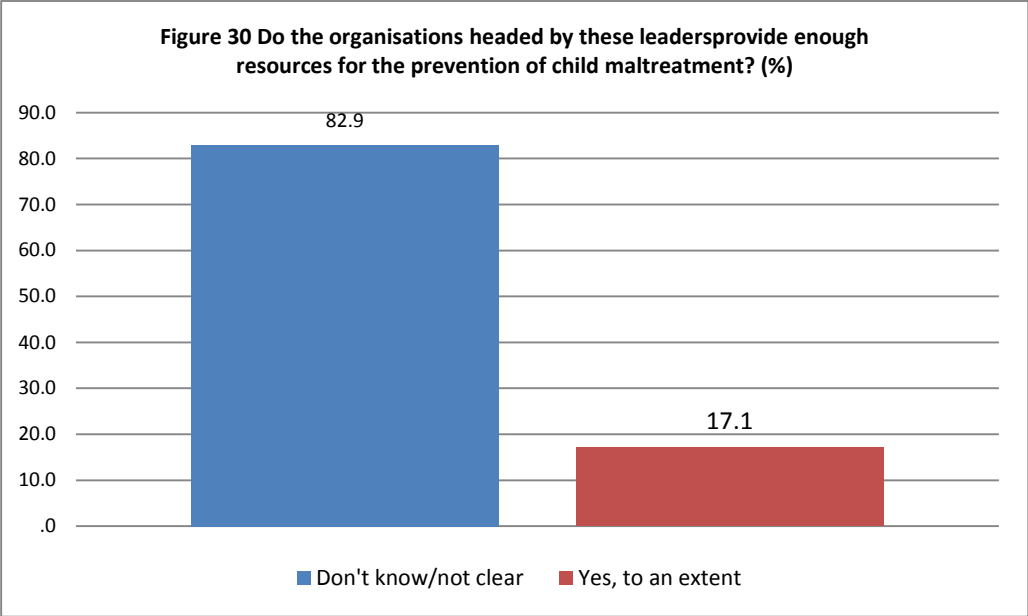
#### **4.6.2 Political will**

Political will is critical for effective child maltreatment prevention in a country or political jurisdiction. It refers to the degree to which political leaders actively give attention to the issue, and back up that attention with funding, technical, and human resources. Key informants were asked if there were political leaders who expressed strong commitment to the issue of child maltreatment prevention and if they were taking effective measures to address the problem.

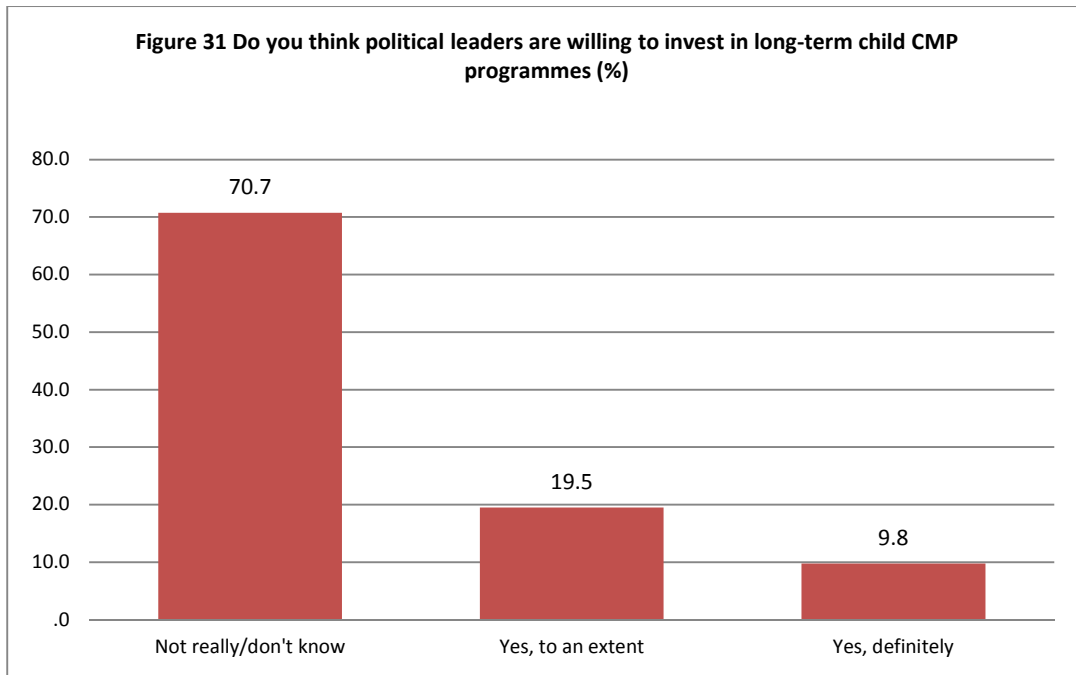
The results suggest a weak political will to take effective measures to address the child maltreatment problem. Most interviewees (58.5%) held the view that political leaders unquestionably expressed strong commitment to the issue of child maltreatment prevention and were taking effective measures to address the problem. In comparison, 39% believed this was not the situation or they did not know to what extent political leaders were committed to preventing child maltreatment (Figure 29).



Regarding whether organisations led by these leaders provided enough resources for the prevention of child maltreatment, an overwhelming majority of interviewees (83%) stated that it was not clear if these political leaders did, or they did not know about how they allocated resources towards preventing child maltreatment. Less than one fifth (17%) of the interviewees stated that the leaders supported child maltreatment prevention with resources (Figure 30).



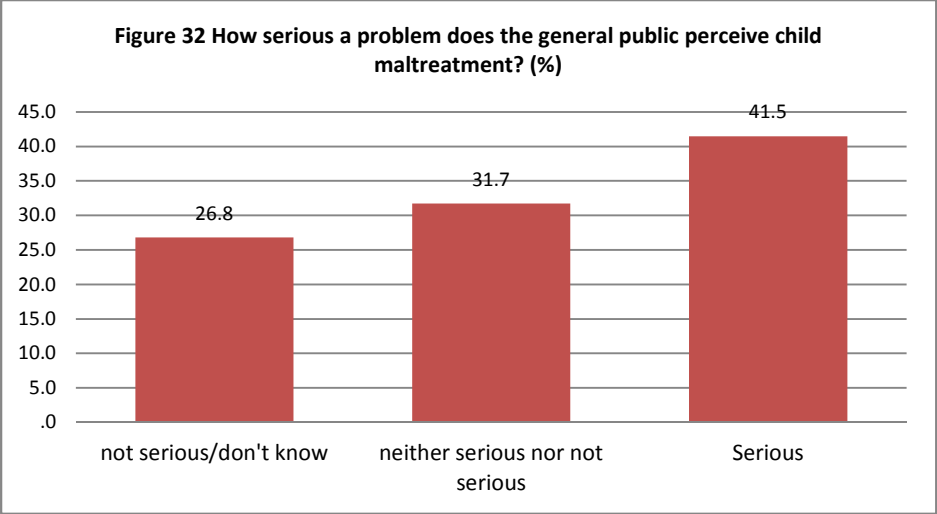
Regarding whether political leaders were willing to invest in long-term child maltreatment prevention programmes, majority of interviewees (71%) stated that political leaders were not willing. About one fifth (19.5%) were of the view that political leaders were to an extent willing to invest in long-term child maltreatment prevention programmes which may show few immediate results in a political cycle. Only about 1 in 10 interviewees said that political leaders were definitely willing to invest in long-term child maltreatment prevention programmes (Figure 31).



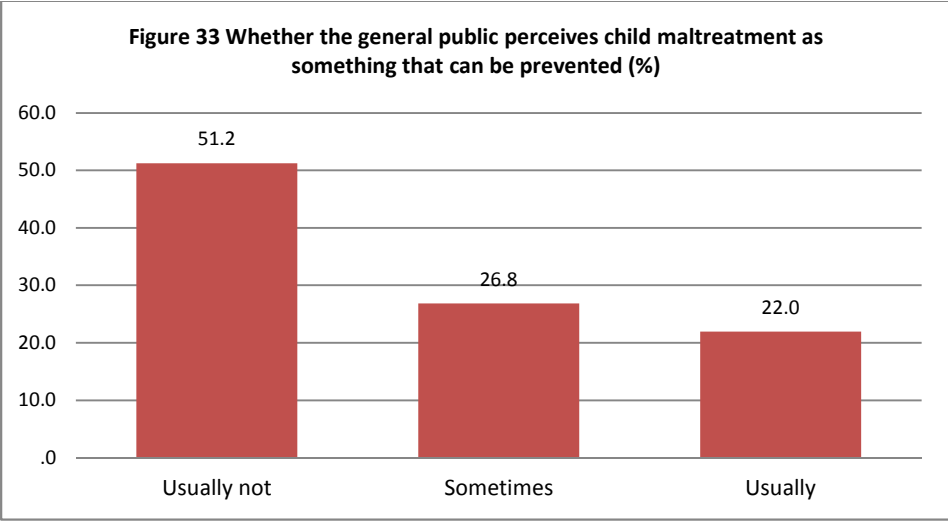
Some interviewees were critical of the role of political leadership indicating that issues relating to children’s safety were only emphasised on special days on the international calendar or when there was a high profile incident reported in the media; there was a lack of programmatic work to systematically address the problem. Others identified reasons for low investment in prevention of child maltreatment to include competing needs in the context of high inequalities and what seemed to be a lack of knowledge among the leadership about what to do to prevent high incidences of child abuse.

#### **4.6.3 Public will**

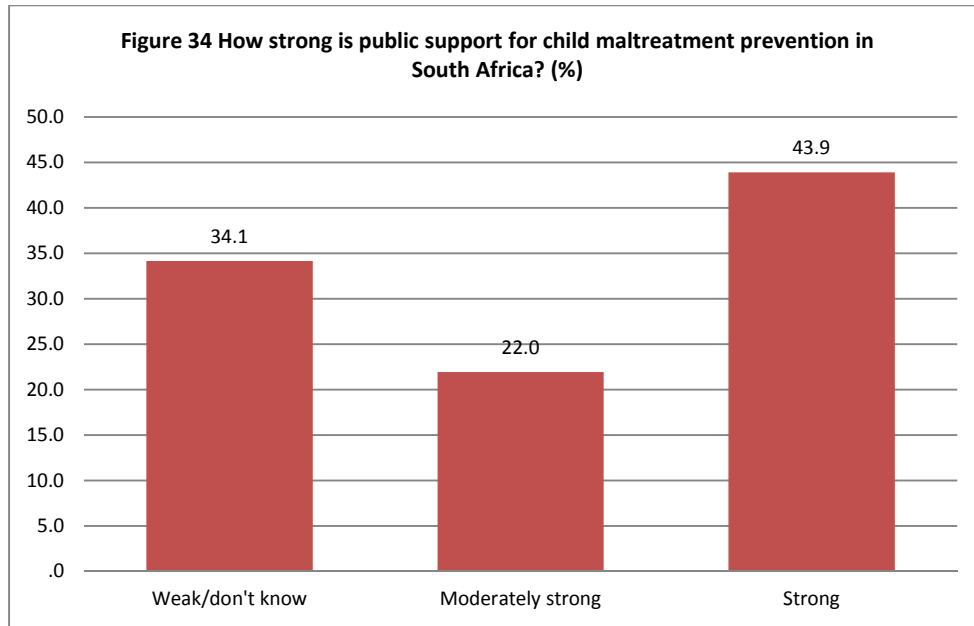
The perception of the interviewees is that the public will to prevent child maltreatment is weak. Their response to how serious the general public perceived the problem of child maltreatment is ambiguous. About 27% of the interviewees thought that the general public did not perceive child maltreatment as a serious problem. Most of the interviewees (41%) thought the general public perceived child maltreatment to be a serious problem (Figure 32).



Most interviewees believed that the public perceived child maltreatment as *usually not preventable* (51%) and 27% believed the public perceived the problem as *sometimes preventable* while only (22%) were optimistic, saying that the public perceived child maltreatment as *usually preventable* (Figure 33).



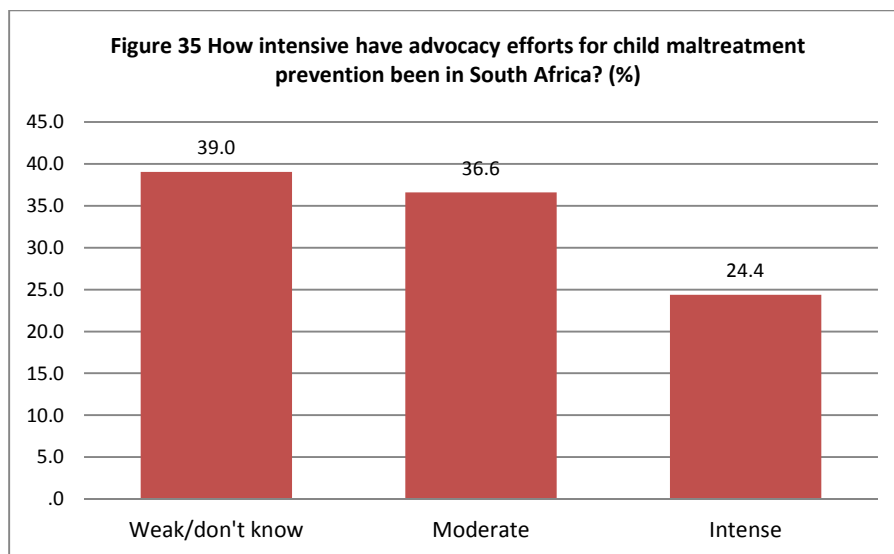
About 44% of the interviewees viewed public support for the prevention of child maltreatment as strong compared with 34% who said it was either weak or they did not know how to assess it. About one fifth (22%) perceived public support for child maltreatment as moderately strong (Figure 34).



One of the views was that the public and government did not prioritise children’s issues; some human rights institutions placed more focus on adult issues than children’s. They also stated that the public was less aware of the ubiquitous nature of the problem since the media tended to alert the public to the more dramatic incidents of child abuse, especially sexual abuse and child homicides. What is needed is a culture of promoting the rights and care of children to safeguard their wellbeing instead of focusing on wrongs.

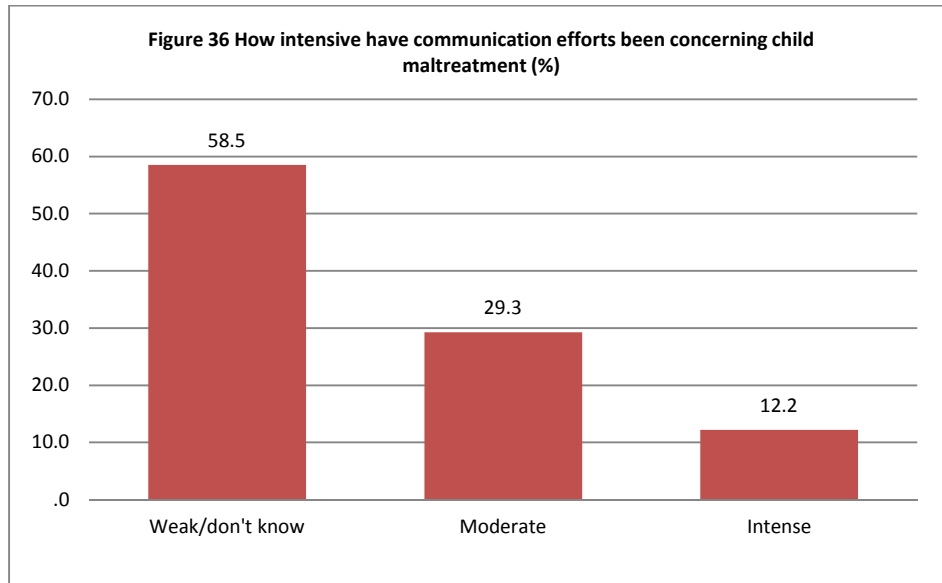
#### 4.6.4 Advocacy

Interviewees were asked to gauge the intensity of advocacy efforts for child maltreatment prevention. Most of the interviewees stated that advocacy efforts have been weak (39%) and 36.6% of respondents thought advocacy had been moderate. Only about a quarter (24%) said advocacy was intense (Table 35).

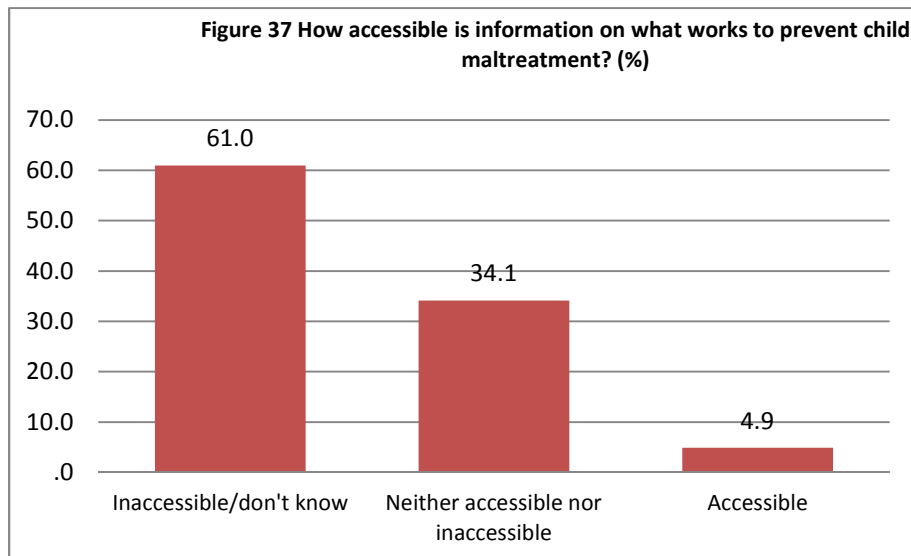


#### 4.6.5 Communication: intensity and accessibility

Majority of interviewees (58.5%) found communication about child maltreatment prevention to be weak or they did not know how intense it was, while 29% stated that communication was of moderate intensity. Only 12% of the interviewees described communication efforts concerning child maltreatment prevention as intensive (Figure 36).



Only about 5% of interviewees stated that information on child maltreatment prevention and scientific information on what works to prevent child maltreatment was accessible. Almost two thirds of the key informants described information as inaccessible. More than one third (34%) of the interviewees said information on child maltreatment prevention was neither accessible nor inaccessible (Figure 37).



The examination of the will to address child maltreatment through prevention measures in South Africa shows that while the commitment of the leadership was favourably assessed, in most situations it was criticised for being mere rhetoric. Currently, the leadership messages do not involve tangible decisions including support through resource allocation. Communities contribution to social solutions could be enhanced through information and communication.

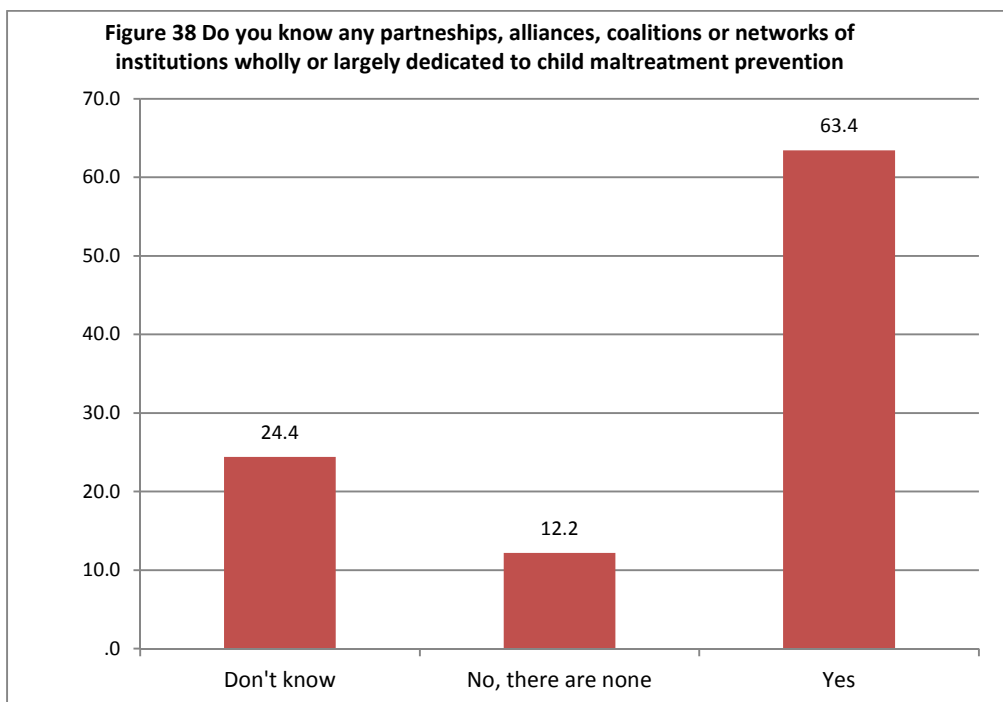
#### 4.7 Dimension 7: Institutional links and resources

This section focuses on partnerships, coalitions, networks, and alliances between institutions dedicated to child maltreatment prevention in South Africa and the Western Cape Province. It examines the extent to which the institutional links involve different sectors such as health, justice, law enforcement, education, social welfare or development, or employment and civil society.

Both national and provincial key informants characterised the presence of institutional links and resources for the prevention of child maltreatment to be moderate.

The composition of the identified institutions included government departments, international organizations working in the country, NGOs, community-based organizations, funding organizations, professional and religious groups, the media, the private sector and others.

The majority of the interviewees (63%) stated that they could identify formal institutional links dedicated to child maltreatment prevention. About one quarter (24.4%) stated that they did not know such links and only 12% said institutional links dedicated to child maltreatment prevention did not exist (Figure 38)





Interviewees were able to list links of institutions that are wholly or partly dedicated to child maltreatment prevention. Most of them are a direct response to the HIV and AIDS epidemic in the country but there are several others that focus on children in general (Box 2). Further, most of the partnerships include government departments and the NGOs/NPOs working in the children's sector. While a few were initiated by the government, most of the networks were initiated by the civil society.

**Box 2: Names of partnerships, alliances, coalitions, or networks of institutions in South Africa which are wholly or in a large part dedicated to child maltreatment prevention**

Alliance for Children's Entitlement to Social Security (ACCESS) is an alliance of more than 1200 children's sector organisations committed to working together to realise our vision of a comprehensive social security package that respects the dignity of all and gives practical substance to children's rights.

<http://www.aces.org.za/>. Members are drawn from all of South Africa's nine provinces.

National Association of Child Care Workers (NACCCW) is an association of social care professionals. It is a registered non-profit organization working independently to promote optimal standards of care for orphaned, vulnerable and at-risk children and youth. It was formed as a response to the needs of children affected by HIV and AIDS. The association develops the abilities of those who work directly with the children - child and youth care workers. Membership covers the whole country and is open to organisations outside South Africa. The association has developed a model of child and youth care called Isibindi. In 2011 the model was adopted for scaling up in all the nine provinces <http://www.naccw.org.za/membership/index.html>

Children in Distress Network (CINDI Network) was established in 1996. It is a multi-sectoral network of more than 100 civil society and government agencies (NGOs, CBOs, FBOs, local and regional government departments). The network implements a range of programmes for children affected by HIV/AIDS in the province of Kwa-Zulu Natal (provincial coverage). The broad aim of the network is to assist member organizations to identify and assist children in distress, particularly orphans and other children affected or made vulnerable by HIV and AIDS. The CINDI Network works through the following clusters: community development, home-based care, psychosocial support, children in care, and school and youth development. [www.cindi.org.za](http://www.cindi.org.za)

The National Children's Rights Committee (NCRC) is an umbrella body of non-governmental organisations working on children's issues. The NCRC's mandate is to advocate generally for children's rights in South Africa and specifically for the implementation of the National Programme of Action (NPA), the South African government's strategy to co-ordinate the initiatives of government and civil society to realise the commitments outlined in the United Nations Convention on the Rights of the Child (CRC). The NPA is an integration of all the policies and plans developed by government departments and non-governmental organisations that include the promotion of the wellbeing of children. [http://www.unicef.org/southafrica/SAF\\_publications\\_soulbuddiez.pdf](http://www.unicef.org/southafrica/SAF_publications_soulbuddiez.pdf)

Nelson Mandela Children's Fund (NMCF) The Fund has Champions for Children Campaign (CCC) which is a platform for the association of civil society organizations, donors, business, faith-based and youth representatives united to build and steer a national movement for the protection, safety, care and nurturing of children at all times. <http://www.nelsonmandelachildrensfund.com/sustainability.php>

The Child Care and Protection Forum and Child Protection Committees are national and provincial committees, respectively, established by the Department of Social Development in 2008. The Forums were established in terms of section 4 and 5 of the Children's Act. Their role is to facilitate the co-operation, co-ordination and integration of all government departments and institutions with civil society organisations in the implementation of the Children's Act and related matters. The Forums are umbrella committees for the sectoral committees such as the Child Protection Committee and the National Action Committee for Children and AIDS (NACCA). Each national government department affected by the Children's Act and all provincial Departments of Social Development are represented on the Forum. Civil society consisting of NPOs, FBOs, and research institutions are represented.

Yezingane Network – is the Children's Sector HIV and AIDS National Network of civil society and organisations concerned with children and HIV and AIDS. It has a strong monitoring and advocacy function throughout South Africa and represents children's issues on the South African National AIDS Council (SANAC). Membership includes organisations and individuals from civil society, at local, provincial, regional, national, and international levels. World Vision SA, Child Welfare SA, Rahima Moosa Mother & Child Hospital, Wits University, Gugu Dlamini Foundation, PACE, ELRU, Soul City, Chain Western Cape Province, University of Limpopo, HSRC, Childline South Africa, CINDI, Children's Rights Centre and NACCCW. The network is coordinated by the Children's Rights Centre – an NGO based in Durban. <http://www.crc->

[sa.co.za/yezingane](http://sa.co.za/yezingane)

The National Action Committee for Children Affected by AIDS (NACCA) is a permanent coordinating structure of government departments, civil society, business and development agencies. The committee is led by the Department of Social Development. NACCA's mandate under the Policy Framework for Orphans and other Children Affected by HIV and AIDS is to: "Facilitate and coordinate mechanisms at national, provincial, district and community levels, to alleviate the impact of HIV and AIDS on the lives of children." <http://youngcarers.net.au.net/collaborative.html>

The Child Justice Alliance is an advocacy network of NGOs, CBOs, academic institutions and individuals that worked to ensure that the South African Parliament passed the Child Justice Bill (passed as the Child Justice Act 75 of 2008). Apart from a common interest in the welfare, child justice and rights of children, these people and organisations share a common vision.

The South African National NGO Coalition (SANGOCO) was formed in 1995 to coordinate NGO contribution to government policy in South Africa. The purpose was to ensure that the rich traditions of civil society, established for resistance to apartheid, continued to serve the people of South Africa. The coalition focuses on development and poverty in South Africa.

Action for a Safe South Africa is a coalition of public and private organisations launched in 2008. It is a civil society initiative to address the context and factors that feed the cycle of crime in South Africa and to encourage South Africans to become part of the solution. The Coalition advocates for a safety strategy that shifts from the current focus on security and enforcement to prevention. <http://www.southafrica.info/community/safesa.htm#ixzz118guv6PB>

Social Services Practitioners Advocacy Network (SSPAN) is a network of social services professionals formed in 2008 as an advocacy network to ensure a proper implementation of the The Social Service Practitioners Bill published in the same year. The primary aim of the network is to promote the participation of social service practitioners in the law-making process, particularly in response to the Social Service Professions Bill.

[http://www.ci.org.za/depts/ci/plr/pdf/SSPAN\\_Newsletter\\_March2009.pdf](http://www.ci.org.za/depts/ci/plr/pdf/SSPAN_Newsletter_March2009.pdf)

The SA Working Group on Positive Discipline is a network of organisations collaborating in various ways to prevent and address child abuse and neglect, and ensure the protection of the rights of children. The Working Group has a particular emphasis on the promotion of positive parenting and non-violent discipline, and is committed to the abolition of corporal and all other forms of humiliating punishment of children. It promotes appropriate parenting capacity-building opportunities and strengthening the implementation of positive discipline in schools. The network is working with the National Departments of Social Development and Education. The network established itself out of the Children's Bill Working Group in 2006 in order to advocate for the ban of parental corporal punishment in the Children's Act. <http://www.rapcan.org.za/wgpd/default.asp>

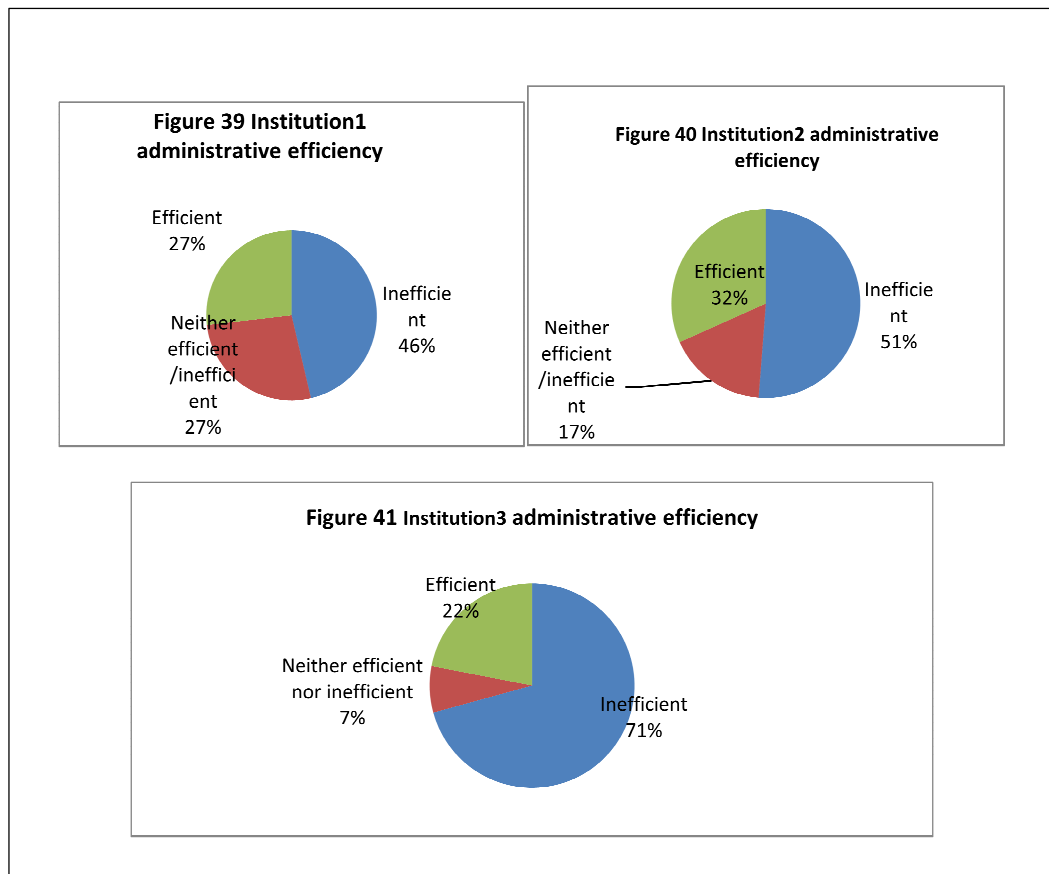
Child Accident prevention Foundation is an NGO established in 1987 to prevent accidental child injuries, disability and death in South Africa. The Foundation has implemented the Childsafe Campaign to promote the safety of children through research and advocacy. The Foundation has branches in Cape Town and Kwa-Zulu Natal. They partner with early childhood development centres, communities, RAPCAN, Medical Research Council and Phoenix Burns Care Programme. [www.childsafe.org.za](http://www.childsafe.org.za)

#### **4.7.1 Institutional resources and efficiency**

The majority of interviewees named at least one to three institutions that were currently involved in child maltreatment prevention. Most of the institutions identified were NGOs, followed by governmental departments and a few international organisations and community-based organisations.

The response rate for the question asking about the number of personnel who were involved in child maltreatment prevention in each named institution was extremely low; most key informants could not provide the details on this aspect. The study could not estimate the numbers of personnel currently providing child maltreatment prevention services.

Most interviewees characterised the named institutions as administratively inefficient (Figures 39, 40 & 41). Administrative inefficiency was attributed to the nature of most of the networks. They tended to be formed by members of the same sector – the child welfare and child rights sector and were long-term goal oriented. There is a critical need to have health professionals (maternity health professionals, paediatricians, child psychiatrists etc.) to be represented in the existing coalitions. Also, some of the coalitions are short-term and pursue time-bound goals. For example, occasionally, such coalitions would advocate for certain aspects in the law and facilitate consultation processes during the formulation of laws, or they facilitate NGO sector report submissions to external stakeholders including the UN and African Union institutions. More long-term formations that monitor and advocate on an on-going basis for the implementation of the various legislations including international laws to which South Africa is a signatory are critical. One such example is the SA Working Group on Positive Discipline network. There should be strong collaboration between government departments and civil society but more importantly civil society should constantly require government departments responsible for ensuring implementation of child maltreatment prevention programmes to be accountable. This role is hampered by what some key informants regarded as a lack of alternative and sustainable sources of funding that are not dependent on government programmes.



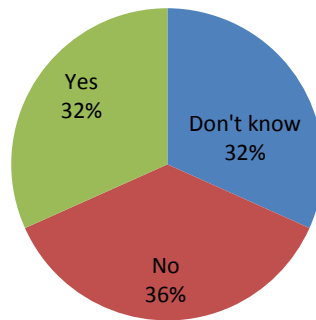
Child maltreatment prevention provides opportunities for institutional and intersectoral collaborations, however, improvement in this approach has lagged behind. Programmes tend to be predominantly vertical and sector specific.

#### 4.8 Dimension 8: Material resources

Interviewees were asked if there were dedicated budgets in different parts of government (e.g. ministries, departments, etc.) in the country as a whole and in the Western Cape Province allocated for child maltreatment prevention. They were asked to evaluate the situation of the infrastructure for child maltreatment prevention services as well.

The scores on this dimension were among the lowest on both the RAP-CM-I and RAP-CM-XD. The interviewees were almost evenly distributed between those who agreed that there were dedicated budgets in government departments for child maltreatment prevention (32%); those who disagreed (36%) and those who did not know whether such budgets existed or not (32%) (Figure 42).

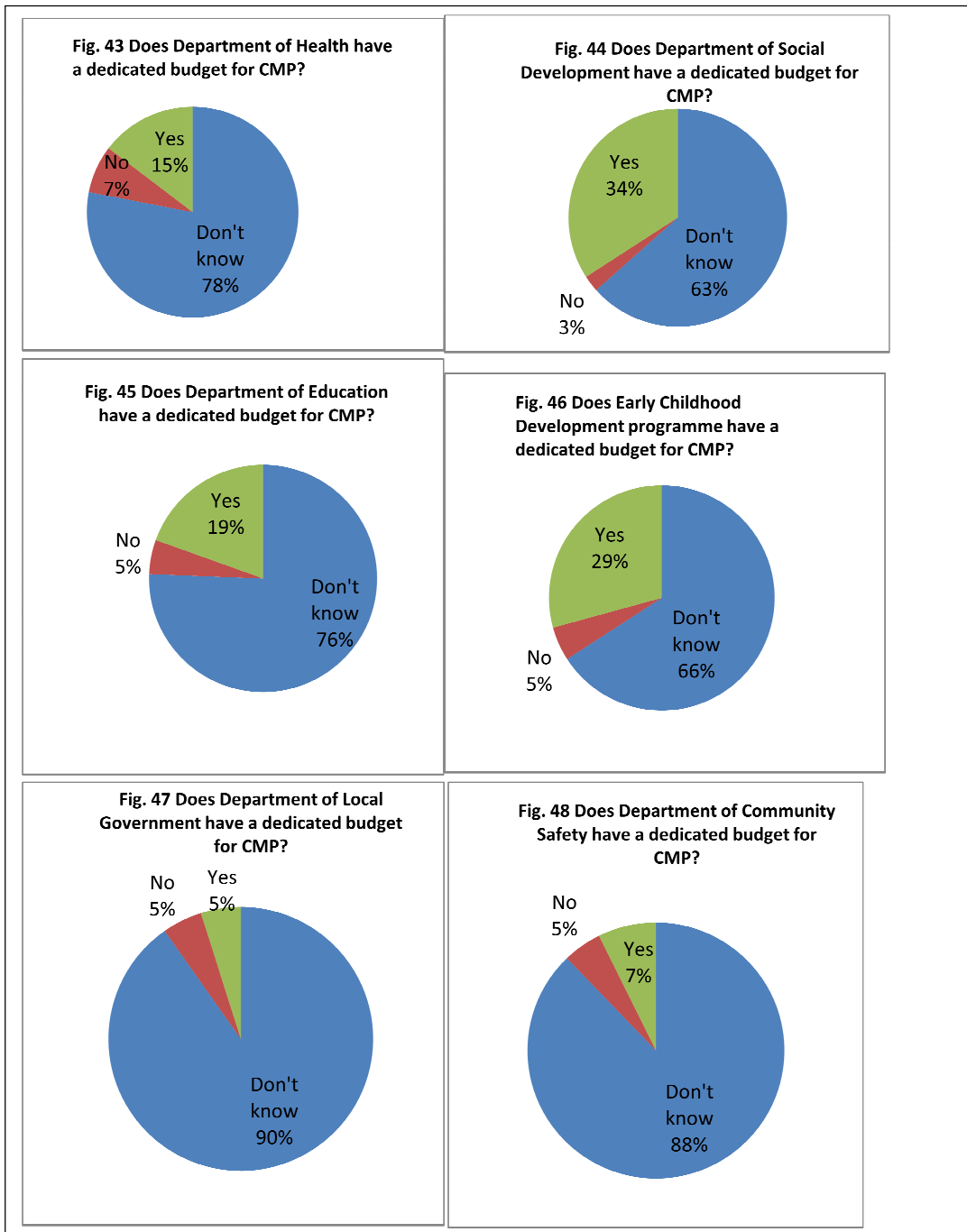
**Figure 42 Knowledge about whether there are dedicated budgets in different parts of government for child maltreatment prevention**



The majority of the interviewees indicated that they did not know if the following key departments and programmes had dedicated budgets for child maltreatment prevention: Health (78%), Social Development (63%), Education (76%), Early Childhood Development programmes (66%), Local Government (90%), and Community Safety (88%) – Figures 43 – 48). Most of the key informants (34%) stated that the Department of Social Development had especially dedicated budgets for child maltreatment prevention, compared with 29% who identified Early Childhood Development programmes; 19% who identified the Department of Education and only 15% who identified the Department of Health.

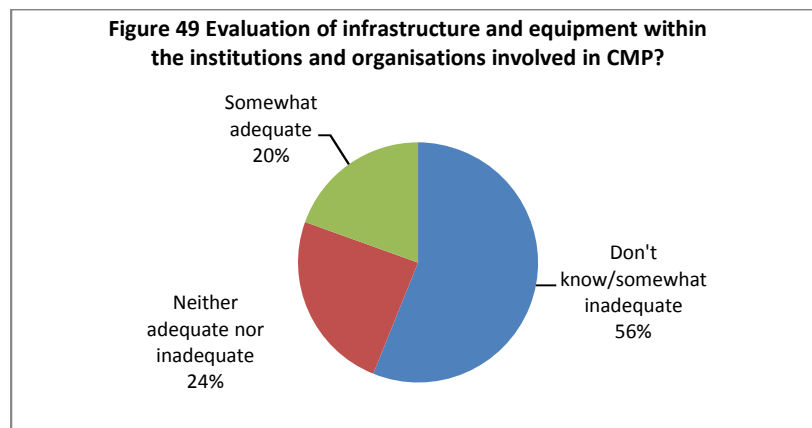
Most respondents indicated that child maltreatment prevention budgets were embedded in the overall budget for child care, protection and child development issues in some of the government departments and programmes. In particular, the Department of Social Development and Early Childhood Development programmes (a component of social welfare programmes) were identified as having budgets dedicated to CMP (Box 3 – Figures 44 and 46). Less than 20% of the interviewees identified Departments of Education and Health as having CMP budgets.

**Box 3 Government departments identified by key informants as having CMP dedicated budgets**



With regard to the attitudes of potential funders, the majority of interviewees (75%) felt that potential funders were supportive to child maltreatment prevention issues. Only 15% of the interviewees thought that funders were unsupportive while 10% believed funders were neither supportive nor unsupportive.

The key informants were also asked to evaluate facilities (office space, meeting rooms) and equipment and materials (computers, phones, vehicles) as part of material resources within the institutions and organisations involved in child maltreatment prevention. The majority of the respondents (56%) said that the facilities for child maltreatment prevention were somewhat inadequate or they did not know about their level of adequacy. Only 20% of the respondents viewed the facilities as somewhat adequate compared with about 24% of the respondents who stated that the facilities were neither adequacy nor inadequacy.



There was a view that well-established organizations were fairly well supported and equipped, and that generally, and smaller organizations especially community-based organisations (CBOs) were not well supported and equipped to address child maltreatment prevention. This is a serious contradiction because CBOs are primarily responsible for non-statutory care work including the prevention of child maltreatment.

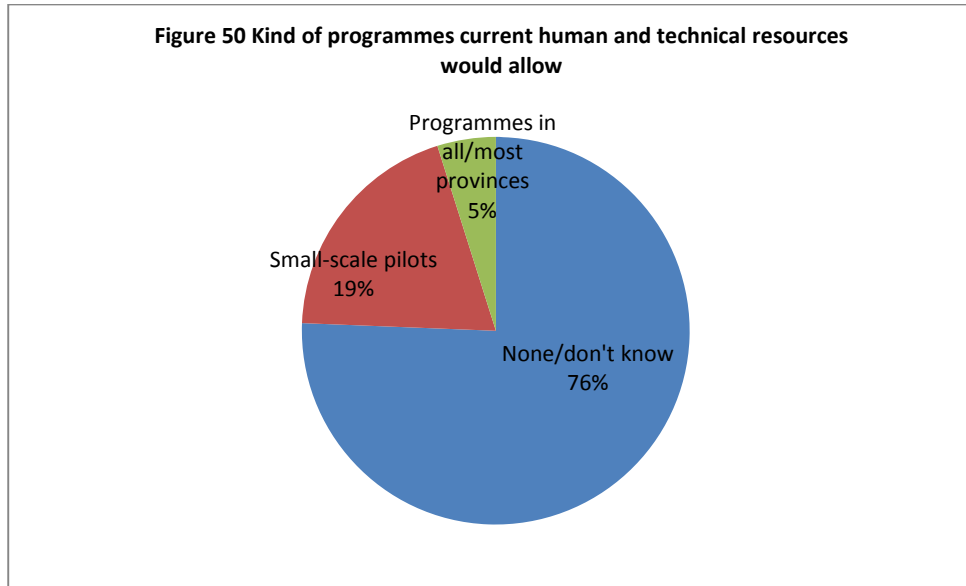
#### 4.9 Dimension 9: Human and technical resources

This section analyses the availability of personnel with specialized technical, administrative, and managerial skills, knowledge, and expertise in child maltreatment prevention in South Africa and the Western Cape Province. The aim was also to gauge the capacity for child maltreatment prevention based on the existing institutions for education and training in child maltreatment prevention in the country.

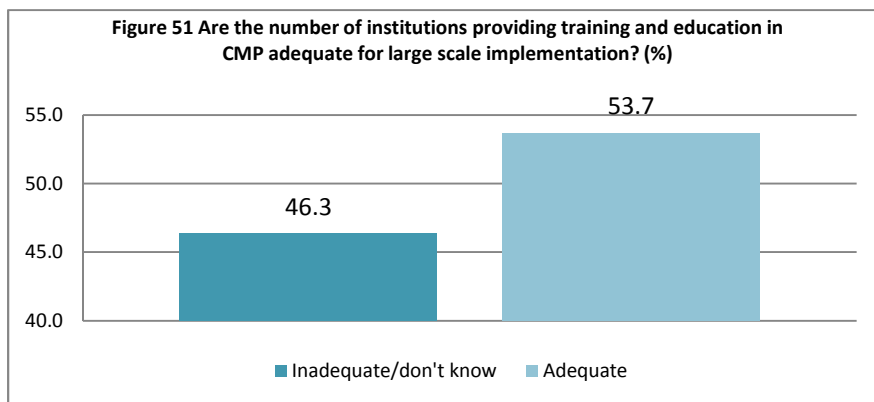
Less than 10% of the key informants thought that the number of professionals specialising in CMP was adequate. An overwhelming majority of the key informants (92.5%) stated that the number of professionals specialising in child maltreatment prevention was inadequate for implementation of large-scale child maltreatment programmes in South Africa and in the Western Cape Province.

Majority of interviewees indicated that current human and technical resources would not allow implementation of large-scale child maltreatment prevention programme of any scale (76%). Only 19% of the interviewees thought that available resources could allow implementation of small-scale pilot programmes either in several areas of the country (national interviewees' view) or in one area of the country (the Western Cape Province). Overall, they did not think the

available resources could allow implementation of CMP programmes in all or most of the provinces (Figure 50).

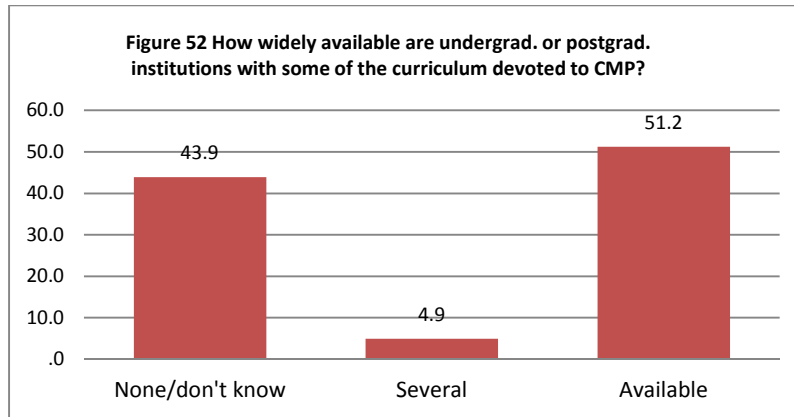


Availability of institutions and training programmes with curriculum components on child maltreatment prevention was assessed. Only over half the interviewees (54%) of the interviewees stated that there were adequate numbers of institutions that provide training and education in child maltreatment prevention to support large-scale implementation of programmes. About 46% stated that they did not know if such institutions were adequate or not or indicated that they were inadequate (Figure 51).



Only about half of the interviewees (51%) indicated that undergraduate or postgraduate educational institutions that devoted some of the curriculum to child maltreatment prevention were available. About 44% stated that such educational institutions were not available (Figure 52).





South African higher education training institutions restructured their social work teaching programmes at the beginning of the last decade to align their programmes to the range of social services and social professions contemplated in the White Paper for Social Welfare. It became necessary to adapt teaching programmes to the developmental social welfare paradigm and shift focus from the therapeutic approach to social welfare services. The extent to which this change would have led to a design of curricula that support large-scale child maltreatment prevention programme implementation needs to be established.

A lack of non-university institutions that offer training in child maltreatment prevention-related skills and opportunities for continuing professional development were reported by almost all the interviewees (more than 90% of the interviewees).

Different NGOs that train community members to identify vulnerable and at-risk children seem to have a narrow focus. The main focus of some of the programmes that have a wide coverage such as the *Isolabantwana* (Eye on the child programmes) of Child Welfare South Africa, is secondary prevention of child neglect, abandonment and abuse. Given their origins as structures that responded to vulnerability caused by HIV and AIDS, some NGOs run programmes that primarily provide services based on the *Policy Framework for Orphans and Other Children Made Vulnerable by HIV and AIDS* (Department of Social Development, 2006). These include Isibindi, which is generally considered a successful model for delivering care services including psychosocial support for vulnerable children.

A more structured form of training is for social work auxiliaries promoted by the Department of Social Development and offered by several accredited private service providers in the country. The Department identifies one of the services provided by social auxiliary worker or community health care worker under the supervision of a social worker as prevention, education and development programmes. Auxiliary workers can work for government agencies and NGOs that provide social welfare services but are particularly needed to expand service delivery to previously under-served populations. Clearly, the optimal benefits of this strategy will depend on a coherent child maltreatment prevention strategy. ([http://www.dsd.gov.za/index2.php?option=com\\_docman&task=doc\\_view&qid=82&](http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&qid=82&))

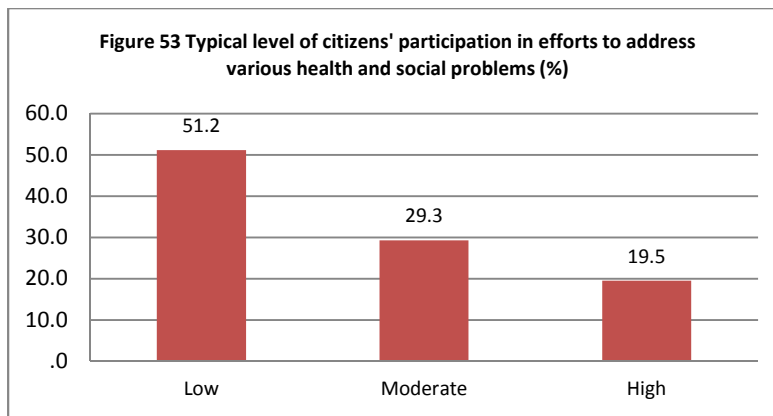
While the number of professionals specialising in CMP and institutions providing training and education in CMP are not adequate for large-scale implementation of CMP programmes, South Africa has begun to explore non-traditional approaches to skills development in the field of child care and early development. These initiatives form part of the shift from the currently predominant tertiary services to prevention consistent with the new legislation and policies.

#### 4.10 Dimension 10: Informal social resources (non-institutional)

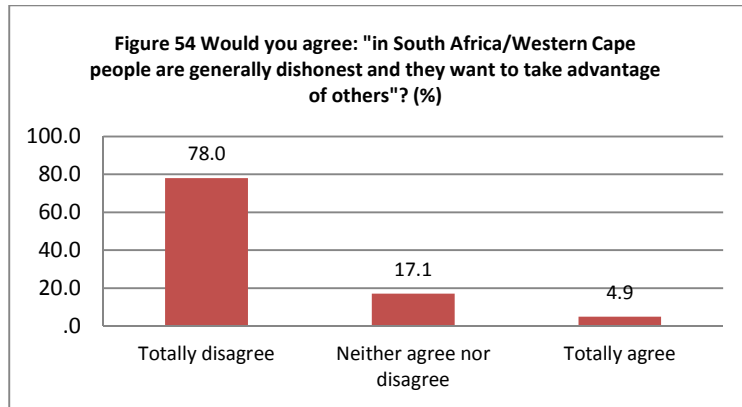
When assessing readiness and capacity, it was important to consider the quality of social interactions and social bonds within a community or society. Many different terms have been used to capture these social interactions and bonds, including social cohesion, social integration, and sense of community. We have decided to call them "informal social resources" to differentiate them from the more formal "institutional resources" we discussed earlier. In the study we assessed informal social resources with five questions on citizen participation, views of others' honesty, reciprocity, civic membership and effectiveness of joint effort in South Africa and the Western Cape Province.

*What level of citizens' participation is there typically in efforts to address various health and social problems in South Africa?* Overall, majority of interviewees stated that there was low citizen participation in efforts to address various health and social problems (51%). About one third (29%) stated that the level of citizen participation was moderate while about one fifth (19.5%) said citizen participation was high (Figure 53).

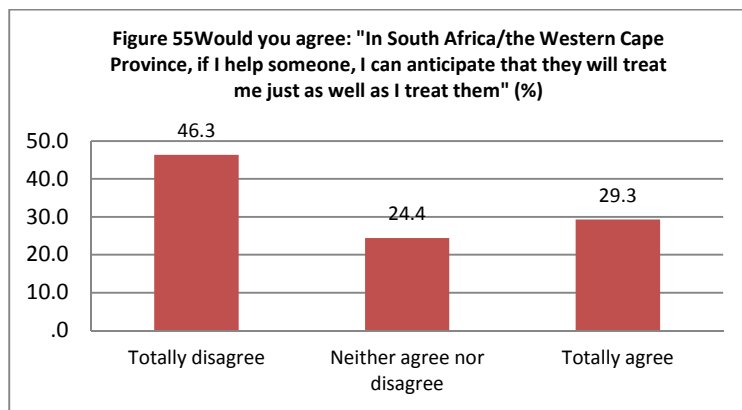
There were differences between national and provincial key informants as the former were more likely than provincial respondents to view the level of citizens' participation as high (43.8% compared with 4.2%) while the provincial key informants were more likely than national key informants to view citizens' participation to address common problems as low (58.3% compared with 31.3%).



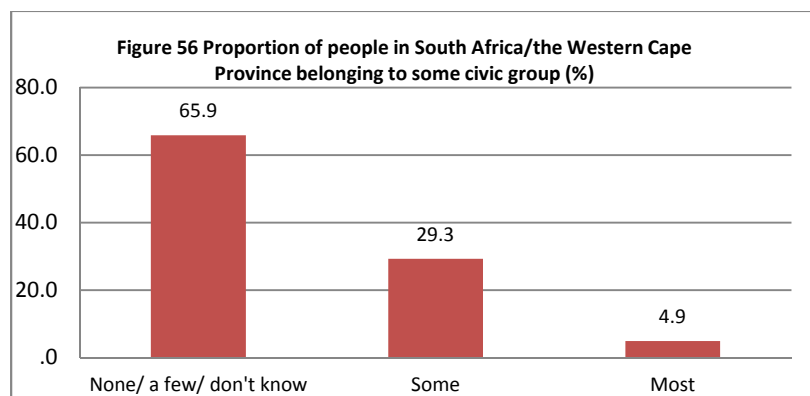
Most interviewees (78%) disagreed with the statement that "in South Africa/Western Cape people are generally dishonest and they want to take advantage of others" (Figure 54).



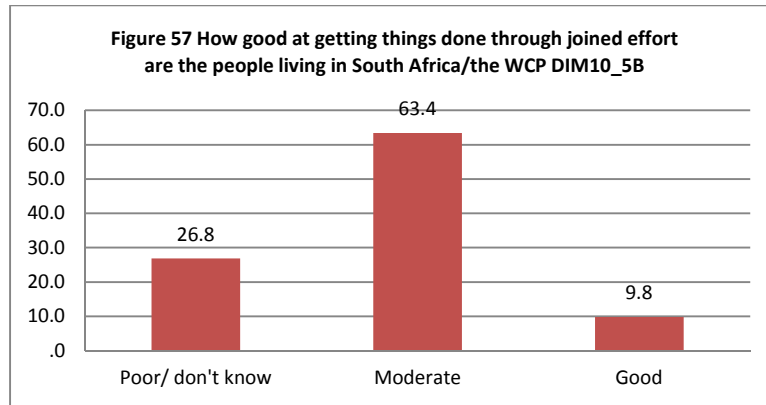
Most interviewees disagreed with the statement that by helping someone one could anticipate that they would be treated just as well by them while about one third of the interviewees agreed with the statement (Figure 55).



Most of the interviewees (66%) stated that they did not know the proportion of people who belonged to civic groups or that there were only a few of them. About 29% of the interviewees stated that only some of the people belonged to civic (Figure 56).



Only about 1 in 10 interviewees believed that people in South Africa were good at getting things done through their joint efforts. Majority of interviewees (63%) believed that people in South Africa have a moderate ability to join efforts and get things done. About a quarter of interviewees believed that people were good at joining efforts (Figure 57).



#### 4.11 Summary

South Africa's total score on RAP-CM-I of 41.4 out of a possible 100 points on the child maltreatment prevention readiness measure among a sample of key informants for child policy and care practitioners and programme managers showed a low level of readiness. The highest score on RAP-CM-I was on Dimensions 2 (knowledge). On *RAP-CM-XD*, South Africa's total score was 46.7. The highest scores were on Dimensions 1 (attitudes), 2 (knowledge), but lowest on Dimension 8 (material resources). A comparison of *RAP-CM-XD* and *RAP-CM-I* showed moderate difference of 5.27; difference of 3.68 on Dimension 4 (programmes) with scores on *RAP-CM-XD* higher; and differences of -2.75 on Dimensions 8 (material resources) with score on *RAP-CM-I* higher. Scores on Dimension 2 (knowledge) were highest for both *RAP-CM-I* and *RAP-CM-XD*.

Overall, there was consistency between the two components of the CMP readiness measure – the *RAP-CM-I* for key informants and the *RAP-CM-XD* completed by researchers based on the available information in the country. The two components had different scores on two dimensions only – Dimension 4 on programmes with the score on *RAP-CM-XD* higher than on *RAP-CM-I*; and differences on Dimension 8 (material resources) with the score on *RAP-CM-I* higher than on *RAP-CM-XD*. Both the *RAP-CM-I* and the *RAP-CM-XD* had highest scores on Dimension 2 (knowledge of child maltreatment and its prevention). The scores for Dimension 2 ranged from 6.9 to 7.3 for the province and national interviewees, respectively.

The assessment showed that based on the opinion of the interviewees and factual information obtainable, South Africa was not ready to implement child maltreatment prevention programmes on a large scale. While legislation and policies on paper were generally judged to be good, their implementation remains inadequate. A particular strength of the country is the knowledge of key players about issue. Two areas of particular weakness are links between, and resources of, institutions involved in CMP, and material resources.

These scores indicate the importance of drawing distinctions between child maltreatment prevention and child protection measures as currently practised in South Africa. For example, the Western Cape Province may have several programmes and services for children affected by child maltreatment. But, the assessment of prevention readiness at the provincial level by key informants indicates that with regard to child maltreatment prevention, the strengths and weaknesses in what is identified as the child protection system, mirror those at the country level.

In South Africa the significance of drawing a distinction between child maltreatment prevention and child protection has until recently been taken for granted, with serious implications for developing capacity to implement prevention measures. The clinical approach, historically dominant in the training of social workers, was used to respond to the social welfare needs of families with children. This approach led to a situation whereby provision of statutory services and especially removal of children in need of care into alternative care becoming a major approach to dealing with child abuse and child neglect. The intention of government to change this practice was made explicit through the White Paper for Social Welfare (South African Government, 1997), and emphasised by the Lund Committee (1997). The White Paper provided a framework for developmental social welfare services for children by emphasizing family focused services and service delivery along a continuum of approaches – prevention, promotion, intervention, and remedial, with emphasis placed on preventive programmes. This delineation of services became central in policy rhetoric which was couched in the ethic of care and safeguarding of children principles. However, there has not been evidence that these values translated into tangible programmes and services for children and families that are at risk of child maltreatment.

Generally, there is a lack of interventions that prevent CM before it takes place – primary prevention interventions. The need to specifically address the gap in prevention programmes is commonly glossed over with the idea that in South Africa child protection is an all-encompassing practice comprising of services provided along the prevention-response continuum. This discourse is formalised through policy statements emphasising that child care and protection services are provided according to the integrated service delivery model (ISDM) consisting of four levels: community awareness and prevention; early intervention with vulnerable carers and families; statutory intervention; and reintegration. But in reality programme interventions have not necessarily been all-encompassing as secondary prevention is more common than primary prevention, and the effectiveness of the former in promoting the safety and wellbeing of children at risk is unknown. Most child welfare organisations use the few human resources available for provision of child care and protection services for high risk children and focus on emergency response (Makoa, Dawes, Loffell & Ward, 2008). There is a disjuncture between policy and practice in this area. It is not surprising therefore, that some of the aspects of the dimensions of the child maltreatment prevention readiness model used in this study are recent developments in the child care sector. For example, South Africa recently completed the child care and protection legal reform which culminated in full adoption of the Children's Act on 1 April 2010, and is in the process of developing a child protection surveillance system.

The Act obliges the provincial departments of social development to provide and fund a variety of services including prevention services for children. These are services provided to families with children in order to strengthen and build their capacity and self-reliance to address problems that may or are bound to occur in the family environment which, if not attended to, may lead to statutory intervention (Martin, 2010). Furthermore, the Act introduced the need to 'safeguard' children. Although, there are no details in the law about what safeguarding would entail in policy implementation, the use of this construct in social policy provides South Africa (as was the case in the United Kingdom) with the opportunity to implement comprehensive programmes across sectors that provide services to families with children from conception throughout childhood and broaden the definition of risk (Lazenbatt & Greer, 2009; Paton, 2011)

The strengthening of monitoring and evaluation systems in various government departments and the requirement for reporting to internal and external stakeholders on international commitments such as the CRC, ACRWC and Millennium Development Goals have led to a

general desire for use of data. The WHO report on prevention of child maltreatment (Butchart, Phinney-Harvey, Kahane, Mian & Furniss, 2006) recommended that countries and the international community should improve social investments in expanding the scientific evidence base for the magnitude, consequences and effective prevention of child maltreatment. But as the analysis shows South Africa lacks mechanisms for collecting the data needed for planning and programming services for children in this sector and ensuring dissemination of research findings on child maltreatment to all stakeholders. There is a high level of knowledge among key players about child maltreatment and its prevention. In particular, the broader societal consequences are well recognised even though the consequences for the health of the child need to be appreciated more.

## 5. Recommendations

South Africa will benefit from placing primary prevention of child maltreatment as a distinct approach to promoting child health, survival, development and protection goals on its political agenda at all levels of governance. The significant shift in legislation and policy from a predominantly responsive child protection system that focuses resources on the investigation of alleged child maltreatment followed by intervention, to a system that emphasises prevention needs to translate into tangible change in practice through programmes and other processes that address harm before it occurs and reduce risk factors at different levels of the child's life. The assessment shows a discrepancy between perceptions about the advancements in the development of legislation and policy and their implementation.

The country has already made impressive milestones in terms of budget allocations and some of the outcomes in other fields related to these goals. Integrating child maltreatment prevention in family health services including maternal health (antenatal care, family planning and reproductive health, mental health), child immunisation, adolescent health, and early childhood development programmes should be considered. This approach will also enhance the existing programmes that target children who are particularly vulnerable because of the weaknesses in the family structure, for example orphaned children.

**Main recommendations:** (1) Place CMP as a distinct approach to promoting child wellbeing high on the political agenda; (2) recognize that prevention works best when integrated into broader programmes, such as maternal health, child immunization, and early childhood development; (3) improve the knowledge of key players about the immediate and long-term consequences of child maltreatment as a means of advocating for more attention to CMP in government departments; (4) increase funding for data collection to understand the magnitude of the problem, in particular for a national prevalence study; (5) advocate for increased political priority and more funds for CMP; and (6) integrate child maltreatment prevention programmes in health services already in place for families, e.g. family planning and reproductive health programmes.

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**Appendix A : RAP-CM-I Interview Schedule (see attached file)**

**Appendix B Comparison of RAP-CM-I National, RAP-CM-I Provincial and RAP-CM-XD scores for each dimension, South Africa**

