

Safeguarding South Africa's future: The need for integrated prevention programmes in child protection

Introduction

Growing evidence from different disciplines shows that child abuse and neglect worldwide have immediate and long-term negative outcomes for human development and population health. In South Africa child protection policy is inclusive and provides for promoting the well-being of families with children, especially poor and vulnerable children in need of care and protection. The White Paper for Social Welfare (1997) and chapter 8 of the Children's Act (No. 38 of 2005 as amended) provide for the implementation and resourcing of primary prevention and early interventions. However, resource allocation, programme landscape and practice in child protection have not shifted from predominantly reactive approaches to preventive approaches. The law specifies collaboration between government departments in the implementation of early intervention and prevention programmes, yet child protection systems remain unintegrated, thus missing the opportunity to implement strategies across the

lifespan of children. Meanwhile, there is a concern that child maltreatment is growing in severity, if not extent, although this perception is primarily based on high-profile media reports. Nevertheless, the evidence base does not identify the predominant measures currently used to curb child maltreatment as effective in reducing either the risk factors of child abuse and neglect or its occurrence. This is because, although they are relevant, they do not emphasise primary prevention despite the fact that the Children's Act clearly recognises the need to move from reactive to proactive approaches. The following recommendations are made: a permanent inter-sectoral government structure led by the departments of social development and health that will mainstream and monitor child maltreatment prevention in all sectors and across the lifespan; retraining of professionals and programme managers in child maltreatment prevention; adoption of the 'safeguarding children' concept in all sectors; and ensuring visibility of child protection issues in healthcare services.

Background

Recent evidence shows that in low- and middle-income countries the incidence of child maltreatment is higher than in high-income countries (MacMillan et al. 2009; Mikton & Butchart 2009; Reza et al. 2009). Growing evidence from different disciplines shows that child maltreatment (different forms of abuse and neglect), as with other adversities during childhood, has immediate and long-term negative outcomes for population health and human development. Injuries, chronic diseases and increased risk of sexually communicable diseases are common among adolescent and adult populations with a history of child maltreatment. Neuroscience has established that child maltreatment has lasting negative effects on brain structure which impact on the victims' functioning at individual and social levels. It exposes victims to substance abuse, mental health disorders (depression, anxiety and suicide), antisocial behaviour, school dropout and risky sexual behaviour (Mikton & Butchart 2009). South Africa does not have an evidence base on long-term follow-up studies regarding the impact of child maltreatment on individual functioning and health status. Evidence from different disciplines indicates that child maltreatment is a serious public health and social problem requiring policies that prioritise implementation of effective prevention programmes. Investment in prevention programmes should be seen as part of the national vision of 'A healthy life for all' and social development.

South African social policy identifies child protection as an inclusive concept that involves provision of support to families with children but, as in the pre-democracy era, institutional and organisational arrangements as well as practice are still inclined towards providing reactive services. Prevention

of child maltreatment and provision of services including alternative care for abused and neglected children are conceptualised along a continuum of interventions. This policy orientation is consistent with the child welfare response identified by Connolly et al. (2006) as the family support orientation which promotes prevention measures that are broadly placed to permeate the welfare system. Heckman (2012) points out that complementary policy across different sectors can be exploited to realise the benefits for human development throughout the lifespan. In health, the approach is distinguished as primary prevention used to prevent the onset of disease (Heckman 2012). In childcare and protection, Munro (2011) refers to the approach as providing 'early help' services to families and children. Influenced by the public health approach, Mikton et al. (2013) indicate that trying to prevent child maltreatment before it occurs constitutes child maltreatment prevention, while responding to cases of child maltreatment after they have happened by providing services, support and treatment constitutes child protection.

A comprehensive primary prevention strategy for child maltreatment is dependent on both formal resources such as institutional arrangements and professional values that are based on collaboration and integration of children's services and informal resources such as community values and networks (Horwath & Morrison 2007; Krug et al. 2002). Additionally, prevention requires a reasonable understanding of the risk factors associated and causally linked with child abuse and neglect in families and communities, making communication between agencies that interact with vulnerable families and collection of routine data important ingredients of effective prevention responses.

Contrary to the national policy discourse that emerged in post-1994 South Africa, child protection practice continues to lean towards reactive responses at tertiary level of intervention with far-reaching social and health consequences for children. The White Paper for Social Welfare (1997) and chapter 8 of the Children's Act provide for the implementation and resourcing of primary prevention intervention services for vulnerable families at provincial level. Child welfare services are provided through partnerships between the Department of Social Development and non-governmental organisations (NGOs). The policies and financing criteria of the Department of Social Development prioritise transformation of social services by specifying 'implementation of programmes aimed at early intervention and prevention', with services provided by a variety of social service practitioners and not social workers only, as some of the requirements for government subsidy (DSD n.d.). However, programme implementation in the sector has not significantly shifted from predominantly reactive measures towards interventions that build the capacity of families to care for their children.

Although the mandate of child protection authorities was expanded through the new legal and policy framework, the majority of the NGOs formed before this policy reform do not seem to have evolved their strategies to address the new mandate beyond issues of equity and inclusion. It would seem that there has not been effective leadership on the part of senior government management to ensure compliance by partners with the new legislative framework, which emphasises prevention services for children. For example, there is a consensus among senior planners, practitioners and researchers in the childcare field that more resources are used for the

provision of response services than for prevention programmes (Makoae et al. 2009). Response services are led by specialist social workers and there is a chronic shortage of these skills and high caseloads in statutory intervention services. The main consequence of the status quo is the lack of desirable outcomes in the lives of children at risk of abuse and neglect.

A transformative legislative framework and the rich tapestry of organisational resources that are supported through public funding to provide child protection services seem ineffective in reducing the concerning levels of violence against children in the country. This situation has led to a reflective process in high-level government structures epitomised by the reopening of family violence, child protection and sexual offences units in police stations and the establishment of the Inter-Ministerial Committee (IMC) on Violence Against Women and Children in 2012. The task of the IMC is to develop a comprehensive strategy for the elimination of violence against women and children. The developments, in the form of commissioned studies, that have occurred since this pronouncement clearly indicate that prevention of violence against children, including child maltreatment, has assumed unprecedented priority status on the South African political agenda. The environment is conducive for policy, research and practice to share knowledge about strengthening primary prevention interventions that can lead to reduction of risk factors for and occurrence of child maltreatment in families and communities.

To a large extent, poor policy implementation has allowed pre-1994 service organisation, practices and a cultural system of how state resources should be used to intervene in the lives of at-risk children and their families to linger on in social services. Two factors

could be responsible for poor policy implementation in child protection in South Africa. Most of the key role-players in government and NGO sectors do not distinguish between primary prevention and tertiary interventions and the real consequences for the well-being of vulnerable families and the protection of children from harm. The ambivalence and poor interpretation of the national policy goals has meant ineffective leadership on the part of government. Managers have been unable to monitor performance of service providers in the sector to ensure that the transformation project based on outcome measures in child protection is pursued.

Why primary prevention?

While the current response measures have the potential to reduce harm, they are limited because of their nature. Early intervention and tertiary intervention are implemented where abuse and neglect have been reported, and they tend to be case-oriented. Sometimes they come too late or are not systematically applied and thus fail to minimise serious harm such as emotional trauma; depression; poor health outcomes including injuries and malnutrition; and social tragedies such as suicide, death including infanticide, child homicide and family breakdown. A key explanation is that while retrospective assessments informed by the ecological framework may identify risk factors for child abuse and neglect (Makoae et al. 2008), early and tertiary interventions may only mitigate the harm in the short term but scarcely remove risk factors found in the child victim, perpetrators and the child's environment – the family and community (Makoae et al. 2012). Most importantly, South Africa lacks routinely collected data that can be used to determine risk factors for child maltreatment.

How ready is South Africa to implement large-scale child maltreatment prevention programmes?

South Africa does not have child maltreatment prevention programmes that have been evaluated and tested to scale. The UN High Level Panel on Post-2015 Development Agenda has made a recommendation to include elimination of all forms of violence against children as a target for Goal 11: Ensure stable and peaceful societies. In South Africa, apart from the general recognition among political leaders that the current interventions could be wanting, there is also a changing outlook among policy managers as evident in recently adopted discourse that consistently distinguishes among primary prevention, early intervention and tertiary intervention. This change of attitude about the potential effectiveness of programmes at different levels is necessary for prioritising research and programming in the social welfare sector. The research community has also initiated projects that address knowledge gaps in the field, and these include developing and evaluating prevention interventions at family and community levels. These developments are characterised by dialogues and collaboration between government, NGOs, researchers and international agencies. In many ways, these developments can be seen as having the potential to enhance the readiness of South Africa to implement large-scale and evidence-based child maltreatment prevention programmes in future.

South Africa has not yet invested in a child maltreatment prevention strategy that can strengthen capacities of families and communities to bear and bring up children who will not be left behind as the society moves into the third decade of democratic rule and beyond. Instead, they may be left behind simply because they have poor cognitive and socio-emotional

capacity to learn, relate socially, have empathy, avoid risky behaviours and be productive. Heckman (2012) describes research that has demonstrated the health benefits of early-life prevention approaches, including parenting, when implemented using the life-cycle framework. The contemplated national strategy for responding to violence against children including child maltreatment needs to be informed by the ideas about approaches that research has identified as necessary for holistic child maltreatment prevention measures. These are 'starting early', 'child-centred services through families', using 'evidence-based interventions', and 'integration and coordination' of child-oriented services. Some of the assumptions and evidence on the effectiveness of these approaches are briefly identified below.

In South Africa 'early start' has a relatively long history and is well understood and applied to achieving child health goals relating to survival and morbidity, although in child development it emerged as a policy priority only recently. Contrarily, the concept of early start has not yet meaningfully influenced child protection goals. International evidence (Krug et al. 2002) shows that the youngest children (0 to 5 years) are at higher risk of abuse and neglect by parents and caregivers than older children, but high rates also occur in late childhood (15 to 17 years). There is an opportunity for the prevention of child maltreatment through services that families access during the formative phase, namely health services. Violence prevention approaches will require child-centred measures that are implemented during the antenatal, neonatal, infancy, preschool and adolescence phases (Matzopoulos et al. 2008). For the opportunities of early start in the health sector to be exploited for child protection, two distinct approaches are required: proactive

assessment of risk and systemic readiness to provide early help.

Assessment of risk and early help

The ecological framework is widely used in the South African childcare and welfare sector to understand how inter-relationships between children and their environments protect or predispose children to harm. In the early years, the behaviour of parents, caregivers and other individuals in the family, as well as neighbourhood socioeconomic conditions, are key protective or risk factors for children's health, well-being and survival, including the occurrence of child maltreatment (Coulton et al. 2007). The direct relationship of these individuals and conditions with the child or their indirect relationship through the mother (in most cases) can affect the development of the child from as early as conception. Research from the United Kingdom (Gonzalez-Izquierdo et al. 2010), United States (Dubowitz et al. 2011; Flaherty et al. 2008), Australia (McKenzie & Scott 2011) and Saudi Arabia (Al-Eissa & Al-Muneef 2010) shows that primary healthcare professionals working in different hospital departments (emergency and paediatric units) play a significant role in identifying child maltreatment. In the United Kingdom there is a growing movement to implement mechanisms that identify child maltreatment risk factors for unborn children in their parents and homes instead of initiating protection only after birth.

In the United Kingdom pre-birth assessment of pregnant women for child abuse and neglect risk is identified as a tool that can be used for early proactive interventions, provided the necessary resources are available to support referrals and services (Hart 2001; Lazenbatt & Greer 2009). Assessments of pregnant women in general are considered useful for analysis of the circumstances of women

that can negatively affect the health and development of children, as well as enabling informed decision-making, planning and intervention. Child protection assessments before the birth of a child are considered a valuable practice in maternity health services and have been found to provide the opportunity to prevent harm to children through abuse and neglect. Risk factors identifiable in maternity settings include attitude towards the pregnancy, maternal alcohol use, domestic violence, drug abuse, maternal depression, plans for childcare, and social support by partner and extended family.

In the United Kingdom this approach is consistent with policy recommendations to provide 'early help' to vulnerable parents and has been identified as crucial for safeguarding the well-being and safety of children (Munro 2011). South Africa has already invested in a commendable programme of social transfers and child survival programmes that have universal coverage. Providing early help to parents would mean that in addition to promoting the survival and economic protection of children, relevant government departments collaborate to provide programmes that empower parents with resources, knowledge and skills to nurture and protect their children. The re-engineering of the primary healthcare (PHC) system provides similar opportunities for child protection pre-birth assessments that are integrated into maternity healthcare. They can be integrated into under-five child healthcare and monitored likewise if the life-cycle perspective is used in addition to the ecological framework already commonly employed.

Many social problems that impact on the survival, well-being, protection and healthy development of children – infanticide, foetal alcohol disorders, malnutrition, poor maternal-child interaction, intimate partner violence,

post-partum stress and homicide – are linked to child maltreatment and can be traced back to a mother's pregnancy. During pregnancy and in the first two years of the child's life, families use health services more than any other social service. This presents all categories of healthcare professionals (obstetricians, midwifery nurses, paediatricians and family physicians) with an opportunity for routine assessment of pregnant women for relationship risk factors such as domestic violence (McFarlane et al. 1992) and attending to anticipated and actual child protection needs of service users through counselling and referrals.

Additionally, factors predicting child maltreatment during the neonatal period persist as predictors of child maltreatment during the first four years of a child's life (Kotch et al. 1999). The significance of pursuing holistic early childhood services for families is well recognised. However, as Shonkoff et al. (2012) point out, the problem lies in government ministries addressing specific aspects of healthy child development separately and without an all-encompassing strategy. This is the case with child protection in South Africa, as evidenced by the lack of a coordinated strategy for prevention and by some elements of the response system including information systems. For example, despite the concern with the devastating impacts of child maltreatment on child health, the healthcare system does not routinely contribute clinical data to the child protection system and healthcare professionals' practices vary when it comes to documenting suspected child maltreatment diagnosis, leading to a lack of knowledge about health consequences of the phenomenon. This gap in child protection practice has implications for the design of effective and comprehensive responses.

Most poor parents and caregivers provide adequate care to their children

(Dubowitz et al. 2011) and they use available services for their own and their children's well-being, but many children are at high risk of child maltreatment because they are born in under-resourced communities; in families that are highly disorganised due to substance abuse, violence and unemployment; and have young parents with weak social support (Coulton et al. 2007). Public investment in interventions that address the risk factors associated with child maltreatment by enhancing the capacity of parents to protect their children and that modify the risk factors of family and neighbourhood contexts ensure children's development, behaviour and health in the present and future. Emphasis is on programmes that reduce stress in children's environments by supporting stable, safe and nurturing relationships with caregivers (Mercy & Saul 2009). Improving the competence of parents with information and knowledge about services they should demand for their children and caregiving skills contributes to family resilience and child well-being. Home visitations for mothers and infants from pregnancy and after birth are identified as strategies for reducing the actual incidence and severity of child abuse and neglect (Olds et al. 1997), while several other home visitation interventions have been found to reduce the risk factors of child maltreatment (Mikton & Butchart 2009).

The literature further indicates that successful attainment of expected child outcomes is realised where programmes are delivered by nurses due to the fact that in high-income societies nurses are considered legitimate authorities that can interact with vulnerable families during pregnancy or post-natally (Olds et al. 2007). The institutional mandates for child health and development in South Africa are consistent with this approach. A possible challenge would be the shortage of nurses in the country, which leaves open the

possibility of exploring the suitability of community health workers for this function under the re-engineering of PHC. Community health workers who are trained and supported through supervision remain a potential resource for child safeguarding; their tasks can be integrated into the home-based care programme.

It is essential that child maltreatment prevention programmes are integrated with other child health and development programmes. The units in all mandated government departments should sufficiently collaborate and communicate information about vulnerable parents, their children, and goals and outcomes. When inter-agency professionals proactively identify risk factors, make referrals and share data on incidence of child maltreatment and monitoring plans, their collaboration can improve children's quality of life and prevent most tragedies. There is a need for a structure that can oversee intra- and inter-governmental collaborations that are generally intended to safeguard children and champion child maltreatment prevention (Horwath & Morrison 2007).

Discussion and policy options

Almost two decades since the advent of a child protection policy that emphasises primary prevention programmes for families with children, South Africa still lacks programmes for prevention of child maltreatment that reach vulnerable families in historically disadvantaged and high-risk communities. South Africa also does not have an effective child maltreatment surveillance system for estimating the incidence of this social and public health problem.

The country has an adequate policy and legislative framework to effect implementation of prevention programmes. This is an important

prerequisite for implementing large-scale programmes, but its effectiveness in bringing about change depends on other elements of any child protection system, which include comprehensive information and monitoring systems, supportive attitudes for prevention, resources and inter-agency collaborations.

Overall, the child maltreatment prevention readiness assessment showed that South Africa lacks programmes for prevention of child maltreatment. However, the country has children's health, early childhood development and child protection programmes that can potentially integrate elements of child maltreatment prevention. Particular opportunity lies in the health sector. While the health sector has intensified interventions that protect children from the antenatal phase, the child protection sector does not have a system of services for supporting families during the pre-birth phase.

The possibility of developing such services depends on a policy that clearly interprets what the Children's Act means by 'safeguarding children'. Currently, this concept is undefined yet it has great potential for promoting holistic child well-being. As Lazenbatt & Greer (2009) state, this is an umbrella concept that enables expansion of roles and exchange of information on families and children across sectors and beyond the conventional child protection practice to include health and education. In South Africa, this approach is primarily constrained by the manner in which services for families are organised and the lack of a link between the child health and child protection information systems. Policies emphasise a continuum of services, but the starting point of the continuum is usually imagined to lie away from the period and place of birth.

South Africa is undergoing another major change in child protection policy marked by emphasis on the implementation of prevention programmes. The existing child protection practice emphasises response measures, but growing reports of child abuse and violence against children in the country suggest that the policy implementation does not have the desired outcomes. As Dr Gro Harlem Brundtland, then director-general of the WHO stated, public health made significant contributions to saving children from disease; however, saving our children from these diseases only to let them fall victim to violence or lose them later to acts of violence between intimate partners ... or to self-inflicted injuries or suicide, would be a failure of public health' (Krug et al. 2002: 14).

Globally there is a significant shift in thinking about how best to respond to child maltreatment. Cognisant of the impacts of child maltreatment on the health and development of children, and its long-term impact on the success of nations to develop human capital and prevent antisocial behaviour (Heckman 2012; Shonkoff et al. 2012), policy recommendations emphasise reduction of risk factors for child maltreatment in early life. Empowering parents with skills and knowledge to influence their beliefs about the rights of children and enhancing their protective capacity at relationship, family and community levels cannot be separated from socioeconomic development programmes. It is efficient to devise inter-sectoral plans for implementation of child maltreatment prevention programmes, which UNICEF and partners refer to as systems thinking in child protection. Services provided by the Department of Health across the lifespan are well placed to strengthen prevention of child maltreatment. In passing the Children's Act there was clear recognition of the need to move from reactive to proactive approaches.

Given the legal framework that is already in place, it is imperative that South Africa, led by the departments of social development and health, implements a coordinated plan to ensure resources, infrastructure and integrated programmes to prevent child maltreatment across the lifespan.

Recommendations

The departments of social development and health should lead a process that will facilitate the implementation of chapter 8 of the Children's Act on prevention and early intervention programmes. This calls for the realisation that the two forms of prevention are distinct and do not affect the quality of life of children in the same way: primary prevention will reduce risk factors for child maltreatment by influencing behaviours in families and communities and preventing its occurrence, while early intervention will mitigate the risk of reoccurrence or effects of maltreatment where it has already happened or is suspected.

1. The Inter-Ministerial Committee on Violence Against Women and Children should become a permanent structure empowered to strengthen prioritisation and monitoring of violence prevention in government-funded programmes.
2. The Department of Social Development and the Department of Health should implement a programme that will retrain child protection professionals who were primarily trained to deliver reactive responses. These departments must collaborate with the Department of Higher Education and other stakeholders such as UNICEF and WHO to review curricula in relevant academic departments of tertiary institutions and the Health and Welfare SETA to build a workforce that has skills for implementing child maltreatment prevention programmes.

3. The departments of social development, health and basic education should collaborate to operationalise the concept of 'safeguarding children' in the Children's Act and within the re-engineering of the PHC framework to provide comprehensive statutory guidance for government and its partners. This step will bring to fruition the inter-sectoral and lifespan approaches to delivering services to vulnerable families with children within the health, early childhood and local government sectors.
4. Maternal pre-birth risk assessment tools should be part of comprehensive child-centred antenatal and post-natal care as well as healthy child development interventions provided in-facility and at home.
5. Develop and support facility-based and home visitations to impart a parenting knowledge and skills programme as part of antenatal and post-natal care services envisaged in the re-engineering of the PHC strategy.
6. The Department of Health should develop protocols for assessing high risk of child maltreatment, including not only sexual abuse but physical abuse and neglect as well, as part of routine antenatal, primary health and home-based care.
7. The departments of social development and health should develop protocols for exchanging information and making referrals for antenatal care and child healthcare users in order to facilitate a comprehensive approach to providing services for vulnerable families: for example, intervening on the basis of alcohol and tobacco use during pregnancy, poor antenatal clinic attendance, birth registration, poor immunisation record, malnutrition, enrolment in

early childhood development and day-care arrangements.

8. The Department of Health should include child protection indicators in current child health surveillance and implement child maltreatment prevention programmes that are integrated with primary healthcare and child wellness programmes.

References

- Al-Eissa M & Al-Muneef M (2010) Child abuse and neglect in Saudi Arabia: Journey of recognition to implementation of national prevention strategies. *Child Abuse & Neglect* 34(1): 28–33
- Connolly M, Crichton-Hill Y & Ward T (2006) *Culture and child protection: Reflexive responses*. London: Jessica Kingsley Publishers
- Coulton CJ, Crampton DS, Irwin M, Spilsbury JC & Korbin JE (2007) How neighborhoods influence child maltreatment: A review of the literature and alternative pathways. *Child Abuse & Neglect* 31(11): 1117–1142
- DSD (Department of Social Development) (n.d.) Policy on financial awards to service providers. Accessed 11 February 2014, http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=45&Itemid=3
- Dubowitz H, Kim J, Black MM, Weisbart C, Semiatin J & Magder LS (2011) Identifying children at high risk for a child maltreatment report. *Child Abuse & Neglect* 35(2): 96–104
- Flaherty EG, Sege RD & Hurley TP (2008) Translating child abuse research into action. *Pediatrics* 122(Supplement): S1–S5
- Gonzalez-Izquierdo A, Woodman J, Copley L, Van der Meulen J, Brandon M, Hodes D, Lecky F & Gilbert R (2010) Variation in recording of child maltreatment in administrative records of hospital admissions for injury in England, 1997–2009. *Archives of Disease in Childhood* 95(11): 918–925
- Hart D (2001) Assessment prior to birth. In JA Horwath (Ed.) *The child's world: Assessing children in need*. London: Jessica Kingsley Publishers
- Heckman JJ (2012) The developmental origins of health. *Health Economics* 21(1): 24–29
- Horwath J & Morrison T (2007) Collaboration, integration and change in children's services: Critical issues and key ingredients. *Child Abuse & Neglect* 31: 55–69
- Kotch JB, Browne DC, Dufort V & Winsor J (1999) Predicting child maltreatment in the first four years of life from characteristics assessed in the neonatal period. *Child Abuse & Neglect* 23(4): 305–319
- Krug EG, Dahlberg LL, Mercy JA, Zwi AB & Lozano R (Eds) (2002) *World report on violence and health*. Geneva: World Health Organization
- Lazenbatt A & Greer J (2009) Safeguarding and protecting children in maternity services: Implications for practice. *Child Care in Practice* 15(4): 313–326
- MacMillan H, Wathen CN, Barlow J, Fergusson DM, Leventhal JM & Taussig HN (2009) Interventions to prevent child maltreatment and associated impairment. *Lancet* 373(9659): 250–266
- Makoae M, Dawes A, Loffell J & Ward CL (2008) Children's court inquiries in the Western Cape province: Final report to the Research Directorate, Department of Social Development, Provincial Government of the Western Cape. Cape Town: Human Sciences Research Council
- Makoae M, Richter L & Jubber K (2012) Maltreatment prevention and the ethic of care. In A van Niekerk, S Suffla & M Seedat (Eds) *Crime, violence and injury in South Africa: 21st century solutions for child safety*. Houghton: Psychological Society of South Africa

- Makoae M Tamasane T & Mdakane K (2009) *An Appraisal of the 2007 Integrated care and protection plan for children in the Western Cape*. A report submitted to the Department of Social Development, Provincial Government of the Western Cape. Cape Town: Human Sciences Research Council. Accessible on <http://www.hsrc.ac.za/en/research-data/ktree-doc/5654>
- Matzopoulos R, Myers JE, Bowman B & Mathews S (2008) Interpersonal violence prevention: Prioritising interventions. *South African Medical Journal* 98(9): 682–690
- McFarlane J, Parker B, Soeken K & Bullock L (1992) Assessing for abuse during pregnancy. Severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association* 267(23): 3176–3178.
- McKenzie K & Scott D (2011) Using routinely collected hospital data for child maltreatment surveillance: Issues, methods and patterns. *BMC Public Health* 11: 7, doi:10.1186/1471-2458-11-7
- Mercy JA & Saul J (2009) Creating a healthier future through early interventions for children. *Journal of the American Medical Association* 301(21): 2262–2264
- Mikton C & Butchart A (2009) Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization* 87(5): 353–361
- Mikton C, Power M, Raleva M, Makoae M, Al Eissa M, Cheah I, Cardia N, Choo C & Almuneef M (2013) The assessment of readiness of five countries to implement child maltreatment prevention programmes on a large scale. *Child Abuse & Neglect*. Accessed August 2013, <http://dx.doi.org/10.1016/j.chiabu.2013.07.009>
- Munro E (2011) *The Munro review of child protection: A child-centred system*. Final report. London: UK Department of Education.
- Olds DL, Eckenrode J, Henderson CR Jr, Kitzman H, Powers J, Cole R et al. (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association* 278: 637–643, PMID:9272895 doi:10.1001/jama.278.8.637
- Olds DL, Sadler L & Kitzman H (2007) Programs for parents of infants and toddlers: Recent evidence from randomized trials. *Journal of Child Psychology and Psychiatry* 48(3–4): 355–391
- Reza A, Breiding MJ, Gulaid J, Mercy JA, Blanton C, Mthethwa Z, Bamrah S, Dahlberg LL & Anderson MD (2009) Sexual violence and its health consequences for female children in Swaziland: A cluster survey study. *Lancet* 373(9679): 1966–1972, doi: 10.1016/S0140-6736(09)60247-6
- Shonkoff JP, Richter L, Van der Gaag J & Bhutta ZA (2012) An integrated scientific framework for child survival and early childhood development. *Pediatrics* 129(2): e460–472, doi: 10.1542/peds.2011-0366

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