

Physical, emotional and sexual child abuse victimisation in South Africa

Findings from a prospective cohort study

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Trinity Term 2014

*Thesis submitted in partial fulfilment of the degree of Doctor of
Philosophy in Social Interventions by stand-alone papers at the
University of Oxford.*

Word count: Approximately 72,000

“My grandmother, she did not allow me to go to school since grade 2. She always took my school uniform and stuffed it down the toilet or burned it. She makes me sleep outside the house with my baby and will not touch her. I can only eat when she leaves the house so the neighbours sometimes give me food. She beats me when she finds out and calls me names.”

(Girl 17, Bushbuckridge)

Publications and presentations arising from this thesis

Published:

Meinck, F., Cluver, L., Boyes, M. & Mhlongo, E. (2014). Risk and Protective Factors for Physical and Sexual Child Abuse Victimization in Africa: A review and implications for practice. *Trauma, Violence & Abuse*. doi: 10.1177/1524838014523336

Under Review:

Meinck, F., Cluver, L. & Boyes, M. Physical, emotional and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators and locations. **Meinck, F.**, Cluver, L. & Boyes, M. Gender differences in longitudinal predictors of child sexual abuse in rural and urban South Africa.

Meinck, F., Cluver, L. & Boyes, M. Household-illness, poverty, disability and child abuse victimisation: Findings from South Africa's first prospective study.

Accepted conference abstracts as oral presentations:

Meinck, F., Cluver, L. & Boyes, M. *Physical, emotional and sexual abuse of children in South Africa: Prevalence, incidence, perpetrators and locations of child abuse victimisation in a large community sample* at International Congress for the Prevention of Child Abuse & Neglect (ISPCAN), Nagoya 2014 (forthcoming).

Meinck, F., Cluver, L. & Boyes, M. *Household illness, poverty, disability and physical and emotional abuse: Findings from South Africa's first prospective study* at International Congress for the Prevention of Child Abuse & Neglect (ISPCAN), Nagoya 2014 (forthcoming).

Meinck, F., Cluver, L. & Boyes, M. *Family AIDS, poverty and child abuse: Findings from South Africa's first prospective study* at International AIDS Conference, Melbourne 2014.

Presentations:

Meinck, F. & Cluver, L. *Factors associated with physical and emotional child abuse in the Western Cape* at OVC in Africa Conference, Johannesburg 2010.

Meinck, F., Cluver, L. & Boyes, M. *Risk and protective factors for physical and emotional child abuse victimisation in South Africa*. International Congress for the Prevention of Child Abuse and Neglect (ISPCAN), Istanbul 2012.

Meinck, F., Cluver, L. & Boyes, M. *Orphanhood and household sickness as predictors of physical, emotional and sexual child abuse*. European Regional Conference on Child Abuse and Neglect (ISPCAN), Dublin 2013.

Meinck, F., Cluver, L. & Boyes, M. *Root-causes of child abuse victimisation in South Africa*. UNICEF South Africa, Pretoria, 25/03/2013.

Meinck, F., Cluver, L. & Boyes, M. *Child abuse victimisation in South Africa*. World Health Organization, Interns for Interns, Geneva, 28/05/2013.

Meinck, F., Cluver, L. & Boyes, M. *Exploring risk factors for child abuse: A prospective study from South Africa*. University of Edinburgh, NSPCC Child Protection Research Centre, Edinburgh, 17/01/2014.

Abstract

Background: Child abuse in South Africa is a significant public health concern with severe negative outcomes for children; however, little is known about risk and protective factors for child abuse victimisation. This thesis investigates prevalence rates, perpetrators, and locations as well as predictors of physical, emotional and sexual child abuse victimisation. It also examines the influence of potential mediating and moderating variables on the relationships between risk factors and child abuse.

Methods: In the first study, a systematic review of correlates of physical, emotional and sexual child abuse victimisation in Africa was conducted. The review synthesised evidence from 23 quantitative studies and was used to inform the epidemiological study. For study two to four, anonymous self-report questionnaires were completed by children aged 10-17 (n=3515, 57% female) using random door-to-door sampling in rural and urban areas in two provinces in South Africa. Children were followed-up a year later (97% retention rate). Abuse was measured using internationally recognised scales. Data were analysed using descriptive statistics, multivariate logistic regressions, and mediator and moderator analyses.

Results: The first study, the systematic review, identified high prevalence rates of abuse across all African countries. It identified a number of correlates which were further examined using the study data from South Africa. The second study found lifetime prevalence of abuse to be 54.5% for physical abuse, 35.5% for emotional abuse, 14% for sexual harassment and 9% for contact sexual abuse. Past year prevalence of abuse was found to be 37.9% for physical abuse, 31.6% for emotional abuse, 12% for sexual harassment and 5.9% for contact sexual abuse. A large number of children experienced frequent (monthly or more regular) abuse victimisation with 16% for physical abuse, 22% for emotional abuse, 8.1% for sexual harassment and 2.8% for contact sexual abuse. Incidence for frequent abuse victimisation at follow-up was 12% for physical abuse, 10% for emotional abuse and 3% for contact sexual abuse. Perpetrators of physical and emotional abuse were mostly caregivers; perpetrators of sexual abuse were mostly girlfriends/boyfriends or other peers.

The third study found a direct effect of baseline household AIDS-illness on physical and emotional abuse at follow-up. This relationship was mediated by poverty. Poverty and the ill-person's disability fully mediated the relationship between household other chronic illnesses and physical and emotional abuse, therefore placing children in families with chronic illnesses and high levels of poverty and disability at higher risk of abuse.

The fourth study found that contact sexual abuse in girls at follow-up was predicted by baseline school drop-out, physical assault in the community and prior sexual abuse victimisation. Peer social support acted as a protective factor. It also moderated the relationship between baseline physical assault in the community and sexual abuse at follow-up, lowering the risk for sexual abuse victimisation in girls who had been physically assaulted from 2.5/1000 to 1/1000.

Conclusion: This thesis shows clear evidence of high levels of physical, emotional and sexual child abuse victimisation in South Africa. It also identified risk and protective factors for child abuse victimisation which can be used to inform evidence-based child abuse prevention interventions.

Acknowledgements

This thesis would not have been possible without the support of numerous individuals and institutions. I am most indebted to the children in South Africa who shared their stories and their hardship for this study. I was moved and inspired by their resilience and their willingness to participate in this research.

Generous financial support from the Economic and Social Research Council (ESRC), the National Research Foundation, the John Fell Fund, the Claude Leon Foundation, the Nuffield Foundation, the Health Economics and HIV/AIDS Division at the University of KwaZulu-Natal (HEARD), the European Research Council (ERC) and the Department of Social Development made this study possible. Furthermore substantial financial support from the ESRC for my studentship made this DPhil possible and is gratefully acknowledged.

I also wish to thank my field team, Lodrick Ndhlovu, Rirhandzu Sibiya, Abgail Masiya, Franklin Nonyane, Lydia Ngomane, Sam Madalane, Thabisile Mokoena and Mildred Mkhathswa for your tireless efforts in trudging along dusty roads in the heat trying to find each and every one of our kids. To the team in the Western Cape, the data capturers Prince Ndlozi and Aubrey Chiloane and to everyone at the Rural AIDS Development Action Research (RADAR), I thank you for your hard work and dedication to this project. Julia Rosenfeld, thank you for sharing the heartbreak and the joy and for working so so hard!

I wish to thank my supervisors, Dr. Lucie Cluver and Dr. Mark Boyes. Your unfailing support through this thesis process has been so essential for my academic and personal wellbeing. You both made me want to strive to excel. You have shown by example how dedication, passion, commitment and excellent research can influence policy making for vulnerable families and their children in South Africa. I will be forever grateful for your encouragement, enthusiasm, guidance, wisdom and the doors you have opened for me.

I owe my friends and colleagues from Bolzano, Oxford, Cardiff, South Africa and across the world who provided constant emotional support, encouragement and feedback. I especially thank Jennifer Rabedeau to whom I am most indebted for proof-reading and editing this thesis within the time frame of a just a few days. All persisting language glitches are entirely my fault. I also thank Philippa Tomczak for the constant support and enthusiasm in stopping me from ‘dicking around’.

I wish to also thank Prof. Frances Gardner, Prof. Lucy Bowes, Prof. Cathy Ward, Dr. Mosa Moshabela and Dr. GJ Meldendez-Torres for their advice concerning this research.

Finally, none of this would have been possible without the continuing support from my parents, Hans-Michael and Anne-Marie Meinck, my sister Friderike, the extended family network of Meincks and Schillers, and Thees Spreckelsen. All of you kept me sane while I was in the field, and later when I was agonizing over analyses, tables and formatting. Thank you!

Note on the Candidate's Research Role

Wider project information

All of the data used in this thesis were collected as part of the Young Carers Project (www.youngcarers.org.za), a one-year longitudinal study into children's well-being in the context of HIV/AIDS from 2010-2011 and 2011-2012. This project was a collaboration between the University of Oxford, the University of KwaZulu-Natal in Durban, the University of Cape Town, Brown University in Providence, the national South African Departments of Health, Social Development, Basic Education, Agriculture, Forestry and Fisheries, Cape Town Child Welfare, and the Rural Action Development Research Project at the University of Witwatersrand in Johannesburg.

The survey was funded by the Health, Economics and HIV/AIDS Research Division of the University of KwaZulu-Natal (HEARD), the Economic and Social Research Council (ESRC), the Claude Leon Foundation, the National Research Foundation, the Nuffield Foundation and the John Fell Fund. The candidate was funded by an ESRC doctoral studentship.

The overall study was conceptualised by the candidate's supervisor, Dr Lucie Cluver. The scales and measurements for the first round of data collection were selected by Dr Lucie Cluver, Dr Caroline Kuo, Tyler Lane, Kerry Maucheline and Marisa Casale. All data collection was led by Dr Lucie Cluver and Dr Mark Boyes. The baseline data were collected by teams led by Maria Makhambeni and Amy Bustamam (Mpumalanga) and Kerry Mauchline and Somaya Latif (Western Cape). The project provided the candidate with established networks from the first round of data collection which the candidate was able to use, facilitating follow-up. In addition, the funder provided the infrastructure, i.e., car, office, staff, and all fieldwork costs.

The candidate's role

The candidate joined the research project in October 2010, while baseline data collection was underway. Due to the candidate's interest in child abuse victimisation, her first contribution to the study involved the development of an abuse measurement tool and its inclusion in the follow-up questionnaire. The candidate reviewed the literature to find appropriate measures. She then discussed, trialled and improved the newly-developed abuse scale with the help of academics, child protection professionals and people working with vulnerable children in South Africa during a visit in November 2010. The candidate was also responsible for the creation of the dataset in SPSS which would be used for the follow-up data collection. She was subsequently responsible for training the staff in the field on how to use it.

Follow-up data collection commenced in January 2011 in the Western Cape and in June 2011 in Mpumalanga province. The candidate was responsible for the project management and data collection within Mpumalanga province (urban and rural sites) from June 2011 until July 2012. During that time, the candidate trained staff in representing the project to the public and participants and set up and renewed relationships with local governments, NGOs and local communities and their leaders. She interviewed and hired local staff and provided them with training in using the questionnaire, dealing with vulnerable children and managing referrals. She was responsible for personnel decisions; staff supervision; quality control; data control; referrals made to social and health care agencies for children who had disclosed abuse or severe health issues, disclosure issues, budget management, administrative tasks, community relations, and communication and co-operation with government officials, school authorities and the police.

Overall, Mpumalanga province achieved 98.4% retention in the follow-up phase. Over 300 referrals within the province were made to social services, health services, and to the Department of Home Affairs to help children get birth certificates. In addition, the overall

research results of this project were disseminated by the candidate on over 30 occasions to stakeholders and government officials. The candidate also contributed to a report which was used to disseminate findings to the provincial government.

Following data collection the candidate merged and cleaned the dataset with help from Dr Mark Boyes. Tyler Lane was asked at a later stage to assist with some recoding. The candidate conducted all aspects of the literature review. All of the analyses in the papers of this thesis were conducted by the candidate. All of the papers that compose this thesis were conceptualised by the candidate with guidance from Dr Mark Boyes and Dr Lucie Cluver.

Declaration of authorship

I, Franziska Meinck, hereby declare that this thesis is my own work except, where otherwise stated.

Signed: Oxford,.....

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Key terms

Child: A young person below the age of 18 (UNICEF, 1990).

Adolescent: A young person between the ages of 10 and 19 (World Health Organization, 1998b).

Adolescence: A period of transition in the lifespan of a young person which is characterised by a tremendous pace in growth and development (World Health Organization, 1998a).

Child abuse victimisation: Child abuse can be 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’ (World Health Organisation, 1999, p. 29). Child abuse victimisation, violence against children and child maltreatment are often used interchangeably. For the purpose of this thesis, child abuse and child abuse victimisation will be used interchangeably, while the term child maltreatment will not be used. The term violence will be used in the broader context also including acts such as bullying, community violence or domestic violence.

Physical Abuse: The intentional use of physical force against a child which has the potential to be harmful to the child’s development, survival, health or dignity. Physical abuse includes acts such as hitting, beating, kicking, shaking, biting, strangling, burning, scalding, suffocation, poisoning (World Health Organization, 1999).

Emotional abuse: A ‘repeated pattern of caregiver behaviour or extreme incident(s) that convey to the children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another’s needs’. (American Professional Society on the Abuse of Children, 1995, p. 72). These can be acts of commission or omission such as rejecting, isolating, ignoring, terrorizing or corrupting the child (Garbarino, Guttman, & Seeley, 1986). Emotional abuse is a heterogeneous phenomenon, and it may therefore manifest in various ways in different families (Binggeli, Hart, & Brassard, 2001).

Sexual Abuse: Involvement of a child in sexual activities such as exhibitionism, fondling, watching explicit material or intercourse by an adult or other child who is in a position of trust or power over the child, and where the child does not fully comprehend or is unable to give

informed consent or where the act violates the laws or social taboos of a society (World Health Organization, 2006).

Neglect: The omission of a caregiver to aid the development of a child where the caregiver has adequate resources and is in a position to do so. Instances of neglect can include failure to provide adequate health care, education, nutrition, shelter, safe living conditions and support for the child's emotional development. Neglect is therefore distinctly different from impoverished circumstances in which the caregiver may be unable to provide adequate care for the child (World Health Organization, 2002).

Multiple abuse victimisation: For the purposes of this thesis, multiple abuse victimisation is defined as the experience of at least two co-occurring types of abuse, i.e., physical and emotional; emotional and sexual; physical and sexual; or physical, emotional and sexual abuse. Multiple-abuse victimisation is different from poly-victimisation, which is defined as exposure to more than one type of violence, such as child abuse and bullying, or child abuse and community violence (Finkelhor, Ormrod, & Turner, 2007).

Correlate: Variable that is associated with another within a population (Murray, Farrington, & Eisner, 2009).

Risk factor: Attribute, characteristic or exposure of an individual which increases the likelihood of an adverse event. The variable has to be associated with the adverse event and has to precede it (Murray et al., 2009).

Protective factors: A variable that predicts a low probability of an adverse event. Variables which interact with a risk factor to eliminate its effect are interactive protective factors (Farrington & Ttofi, 2011).

AIDS-affected children: Children under 18 years who live in a household in which someone is ill with AIDS (UNICEF, 2006).

Caregiver: The person taking care of a child. It can refer to a parent, family friend, neighbour or other relative. In sub-Saharan Africa, many children are orphaned, have been abandoned by their parents or can't stay with their parents while they are working. Many children are therefore living in the care of a relative -often grandparents, aunts and uncles- or with neighbours without formal agreements or legalised transfer of guardianship.

Orphan: Child under 18 years who has lost one or two parents (UNICEF, 2006).

AIDS-orphaned children: A child under 18 who has lost one or two parents to AIDS (UNICEF, 2006).

Vulnerable children: A diverse range of children with particular needs such as children affected by poverty, children in care, with disabilities or illnesses, whose caregivers have disabilities, mental health or substance misuse problems. Any problem that may affect a child's opportunity or well-being can be considered as vulnerability (Select Committee on Welsh Affairs, 2008).

Home: The place where a participant sleeps at least four nights per week.

Household members: Members of the family are considered to be of the same household if they occupy a common dwelling (or part of it) and are cooking together or for each other and are providing each other with other essentials for living.

Apartheid: Politics of racial segregation in South Africa with political, social and economic discrimination of non-European groups from 1948 until 1993.

Zulu: Language of the Zulu ethnic group.

Xhosa: Language of the Xhosa ethnic group.

Swati: Language of the Swazi ethnic group.

Tsonga: Language of the Tsonga ethnic group.

Sepedi/Northern Sotho: Language of the Pedi or Basotho ethnic group.

Sesotho/Southern Sotho: Language of the Basotho ethnic group.

1 - Introduction

1.1 Background

1.1.1 Global impact of child abuse

Child abuse is a significant public health concern. Globally 40 million children under the age of 15 become victims of child abuse and neglect annually (World Health Organisation, 1999), and 275 million become victims of violence in their own home (UNICEF, 2007). Between 5 and 10% of men and 20% of women worldwide report having been sexually abused as children (World Health Organization, 2006). There are an estimated annual 155,000 deaths of children under 15 years as a result of child abuse and neglect, with children between 0-4 in the highest risk group (Pinheiro, 2006). The risk of fatal child abuse varies by region, with the highest rates for children under 5 years old found in the WHO African Region (World Health Organization, 2002). However, investigations of child deaths in many areas of the world are not carried out routinely, and many fatalities attributed to other causes have been shown to be homicides when reinvestigated (Kirschner & Wilson, 2001). The global burden of child abuse has not and cannot be estimated due to the secrecy surrounding it and the resultant under-reporting (UNICEF, 2011). Many countries have no legal or child protection systems which are able to record incidents of child abuse and respond to them (World Health Organization, 2006).

Consequences of child abuse can be severe and wide reaching. In prospective studies, strong links have been shown between child abuse victimisation and behaviour problems, post-traumatic stress disorder, obesity and criminal conduct. Moderate links have been shown between child abuse and low educational achievement, low skilled employment, depression, suicidal thoughts, alcohol misuse and sexual risk behaviour. Retrospective studies found additional strong links between childhood abuse, drug misuse and teenage pregnancy (Gilbert et al., 2009). Furthermore, longitudinal evidence shows strong links between child abuse

victimisation and future re-victimisation (Bowes et al., 2009; Classen, Palesh, & Aggarwal, 2005). The long-term impacts of child abuse on survivors' lives also create a considerable financial burden in criminal justice costs, productivity losses, child welfare costs, special education costs and child and adult health costs. A US study estimated that the total lifetime economic burden to society associated with just one year of confirmed cases of child abuse was \$124 billion in 2008 (Fang, Brown, Florence, & Mercy, 2012). A 2007 Australian study found the total annual costs associated with child abuse to be AUS \$383 million (Taylor et al., 2008).

The high prevalence rates and considerable negative outcomes for child abuse survivors suggest that urgent intervention is needed to prevent and stop recurring child abuse. However, compared to other considerable health burdens such as HIV/AIDS, obesity, cancer or heart disease, little funding has been spent on preventing child abuse and neglect. Most countries intervene once child abuse has been reported rather than implementing prevention strategies (World Health Organization, 2006). Effective child abuse prevention services span across all professions that work with children. An increased focus is placed on risk factor research in order to develop interventions, conduct intervention research and carry out implementation. Interventions are aimed at both children at high risk of abuse and those who have already become victims (Woodman & Gilbert, 2013). Interventions may inspire policy changes such as the introduction of child protection legislation, changes of cultural norms and reduction of inequalities risk factors (i.e., poverty prevention). They can include providing safe houses and shelters for victims of domestic violence and their children; training healthcare, educational and other professionals working with children, providing training programmes for parents, increasing access to pre-and post-partum healthcare services, educating children about staying safe and reducing risk factors for child abuse victimisation (World Health Organization, 2006).

Most of the evidence on risk and protective factors for child abuse victimisation comes from high income countries. This evidence suggests that risk factors can be present on many different

levels in a child's life. They might pertain to the child's caregivers or the community in which the child lives. Systematic reviews have identified a number of correlates for physical abuse. On the caregiver level, parent anger, family conflict and family cohesion (Stith et al., 2009), parental age, parental abuse history, parenting stress, domestic violence, parental emotional distress, high or negative expectations for the child and parental negative affect were associated with physical abuse. On the family level poor family support and low levels of social support were correlates of physical abuse. Factors associated with physical abuse on the child level were child socialised aggression, attention and internalising and externalising behaviours. At community level, high levels of poverty and lower percentage of two parent families was associated with physical abuse (Black, Heyman, & Smith Slep, 2001a). Research on emotional child abuse victimisation is sparse, but nevertheless, it has identified low family income, child behaviour problems, parental aggression, parental hostility, neuroticism, domestic arguments and poor parental relationships as correlates of emotional abuse victimisation (Black, Smith Slep, & Heyman, 2001). Correlates of sexual abuse victimisation were found to be living in a dangerous community; having a lower IQ; and being a teenager, female or black. Boys with externalising problems and children with a history of sexual abuse were also found to be at risk (Black, Heyman, & Smith Slep, 2001b). The majority of the studies available were from the United States have used cross-sectional designs, and directionality of the association between the correlate and child abuse cannot, therefore, be assumed (Murray et al., 2009).

The majority of research has focused on risk factors for physical and sexual child abuse. Fewer studies focus on emotional abuse. There is a paucity of studies from developing countries which examine risk factors and specific cultural and contextual components which may affect the risk for victimisation. Families in developing countries often experience a multitude of events which may exacerbate the risk for child abuse (i.e., HIV/AIDS, a large disease burden, a significant orphan population, extreme poverty, poor service delivery) or which may reduce that risk (i.e.,

strong community ties, strong attitudes against corporal punishment or underage sex). Available evidence suggests that child abuse may be linked to family health and well-being.

While the issue of child abuse and protection covers a wide range of topics, this dissertation focuses specifically on risk and protective factors for physical, emotional and sexual child abuse victimisation in Africa generally and more specifically in South Africa. This evidence will be critical for formulating effective interventions to stop and prevent child abuse.

1.1.2 Burden and context of child abuse in South Africa

It is difficult to establish the exact burden of child abuse in South Africa. Different forms of abuse receive varying degrees of attention, and there is no aggregated surveillance data for incidents of reported child abuse at either national and provincial levels (Makoe et al., 2009). Official records are often inconsistent and lack information (Makoe, Dawes, Loeffel, & Ward, 2008). Even where child abuse is reported to the authorities and records are kept consistently, the data merely represent the tip of the iceberg (Makoe et al., 2009). However, where prevalence data are available, they show that child abuse is a widespread social problem which needs to be addressed comprehensively (Lachman et al., 2002).

South Africa has an estimated population of 50 million people, with 38% of the population comprised of children under 18 (Hall & Wright, 2001), all of whom have been born into a society no longer subject to racial anti-Apartheid regulations. However, South African society is one of the most unequal in the world (World Bank, 2010). The country has high levels of unemployment, and 26% of the population are estimated to live below the poverty line (UNDP, 2013). South Africa also has a high HIV-prevalence rate: an estimated 17% of the population are HIV-positive (UNAIDS, 2012). HIV/AIDS has impacted on children and families in many ways. Most importantly, an estimated 2.5 million children have lost father, mother or both parents to AIDS (UNAIDS, 2012). This orphanhood crisis has had a considerable impact on the child protection system as resources have been diverted from child abuse response to

provide institutional, kinship and foster care for orphaned children (Lachman et al., 2002). Many children are cared for in kinship arrangements by grandparents or distant relatives who suffer from physical or mental health problems or struggle to deal with possible child behaviour problems or increased economic deprivation (Freeman & Nkomo, 2006; Monasch & Boerma, 2004). Furthermore, an estimated 3.5 million children in South Africa live in a household where someone is ill with AIDS. In addition to HIV/AIDS, the legacy of Apartheid continues to impact family life and child protection. Under Apartheid, the system of migrant labour and special segregation separated working men and women from their families, destroying extended family units which safe-guarded children in the past (Preston-Whyte, 1993).

1.1.3 Child abuse, the policy context

Since the end of Apartheid, South Africa has ratified the United Nations Convention on the Rights of the Child and passed domestic legislation which promotes the safety and well-being of children, such as the Children's Act (Republic of South Africa, 2005). Prior to democratisation in 1994, child protective systems primarily conducted investigations of child abuse and offered services for confirmed cases, all based on racial exclusion. This meant that child protective services were by law unevenly distributed amongst the population, with poor service provision for the black population majority. In order to address the inequalities of Apartheid, South Africa had to carry out comprehensive law reforms. In addition, resources to provide services for the whole of the population instead of a minority had to be mobilized, and new standards and norms for service delivery had to be devised.

From 1994, a shift towards primary prevention and early intervention could be observed (Republic of South Africa, 1997). Due to overburdened systems and resource constraints, however, services continue to focus on confirmed cases of abuse instead of on prevention and early intervention (Makoe, Roberts, & Ward, 2012). Child protective systems have also focused on the large number of orphaned and AIDS-affected children. In recent years, NGOs

and government services have been addressing the needs of these children and increasing their focus on early childhood development. South Africa is also in the process of implementing national child protection surveillance systems. For example, it recently re-instated the Family Violence, Child Protection and Sexual Offences Units to improve services against family violence. It is planned to staff these units with specially-trained officers to reduce the risk of re-victimisation following traumatic events. At present, however, all child support services suffer from a lack of resources, staff and training. Across South Africa, the population to social worker ratio is 5446 to one (South African Institute of Race Relations, 2012). According to the South African Ministry of Social Development, there is currently a social worker shortfall of 77% (Hall & Wright, 2001).

A recent child abuse prevention readiness assessment in South Africa found that while there were very good laws and policies in place, implementation remained inadequate with particular shortfalls in material resources and co-operation between child abuse prevention service providers (Makoe et al., 2012). The Children's Act which was passed in 2005 was e.g. not implemented until spring 2010.

1.1.4 Conceptual Framework

Understanding risk factors for child abuse can be achieved only by examining risks within the context in which they occur. The decision to carry out this research resulted directly from the candidate's MSc dissertation in Evidence-Based Social Interventions at Oxford. The initial project used the first community-based sample of South African children to examine factors associated with physical and emotional child abuse (Meinck, Cluver, Boyes, & Ndhlovu, 2013). The findings suggested that more in-depth research -with a larger community-based sample and longitudinal data- and a clear theoretical framework were needed to establish prevalence and incidence rates as well as risk factors for child abuse victimisation in South Africa.

1.1.5 Theoretical Framework

While early international research focused only on the characteristics and risk factors of the perpetrator (Zigler & Hall, 1989) or the society (Zigler & Hall, 2000), it is now common to use a multi-factorial approach which assumes that the balance of risk and protective factors of the child's environments determines the risk of child abuse (Belsky & Vondra, 1989). The most common theoretical framework for studying risk and protective factors of child abuse victimisation is an Ecological Framework. It helps to provide a structure through which to understand the relationships between individuals and their environments. Bronfenbrenner's Ecological Model of Human Development (Bronfenbrenner, 1979) focuses on the idea that a child's life is comprised of multiple environments, both interlinked and different (i.e., family, school, peers, community, and culture or society) (Figure 1-1). This model was adapted by Belsky for child abuse research (Belsky, 1980). Belsky's adaptation expanded on previous models by assuming that risk factors within the child's environments, or spheres, interact. These spheres are called the ontogenic system, the microsystem, the exosystem and the macrosystem.

The ontogenic system is concerned with personal histories and characteristics of the abuser, i.e., abuse in their own childhood. However, ontogenic factors can never be the sole cause of child abuse victimisation. The microsystem focuses on the child's immediate environment and factors such as behaviour problems. However, while children may play a role in their own abuse, they are not causal of it. For children in South Africa, these might include factors such as family AIDS-illness, orphanhood and household poverty. The exosystem consists of immediate family surroundings such as extended family, friends and community as well as economic structures. Factors within the exosystem can be community violence, community poverty, AIDS-related stigma, social support and poor access to services. The macrosystem is the outermost layer of the ecological model and consists of the culture and society to which the individual belongs. This may include attitudes or government policies towards discipline or violence as well as traditions and beliefs (Belsky, 1980). It is generally assumed that the risk

for child abuse increases when risk factors outweigh protective factors (Belsky, 1993). The presence of child abuse is therefore reliant on ‘the interdependencies and reciprocities among causal variables at different system levels’ (O’Keefe, 1995).

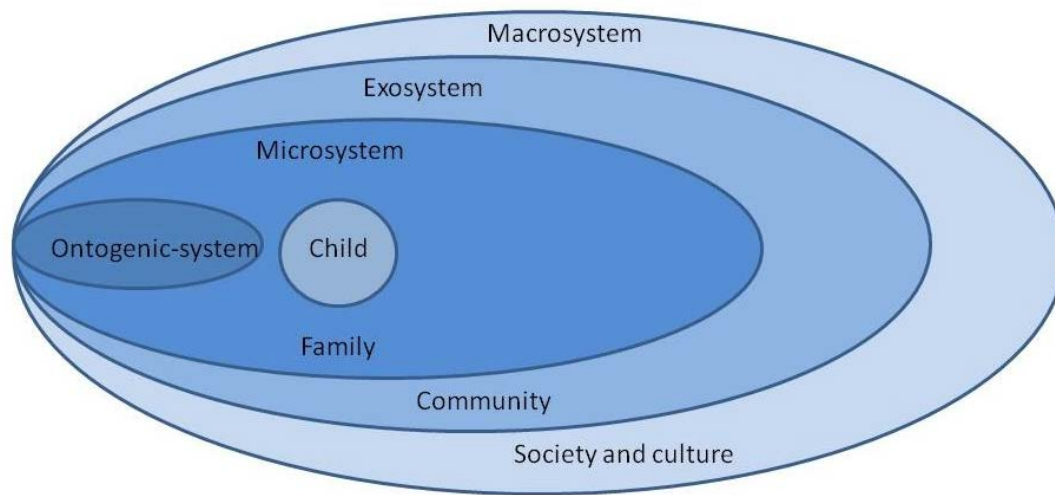


Figure 1-1: Bronfenbrenner Model of Ecological Development adapted by Belsky (1980)

1.2 Methodological Overview

This study was nested within a broader research study called the ‘Young Carers Project South Africa’. The aim of this broader project was to measure educational, physical health, mental health, and social and economic outcomes of vulnerable children in three provinces in KwaZulu-Natal, the Western Cape and Mpumalanga. In particular, the study aimed to investigate the impacts of HIV/AIDS on families and the role of caregiving children in households with ill members. The papers included in this thesis were written using data from Mpumalanga and the Western Cape. Therefore, the methodology for those two provinces is reported here.

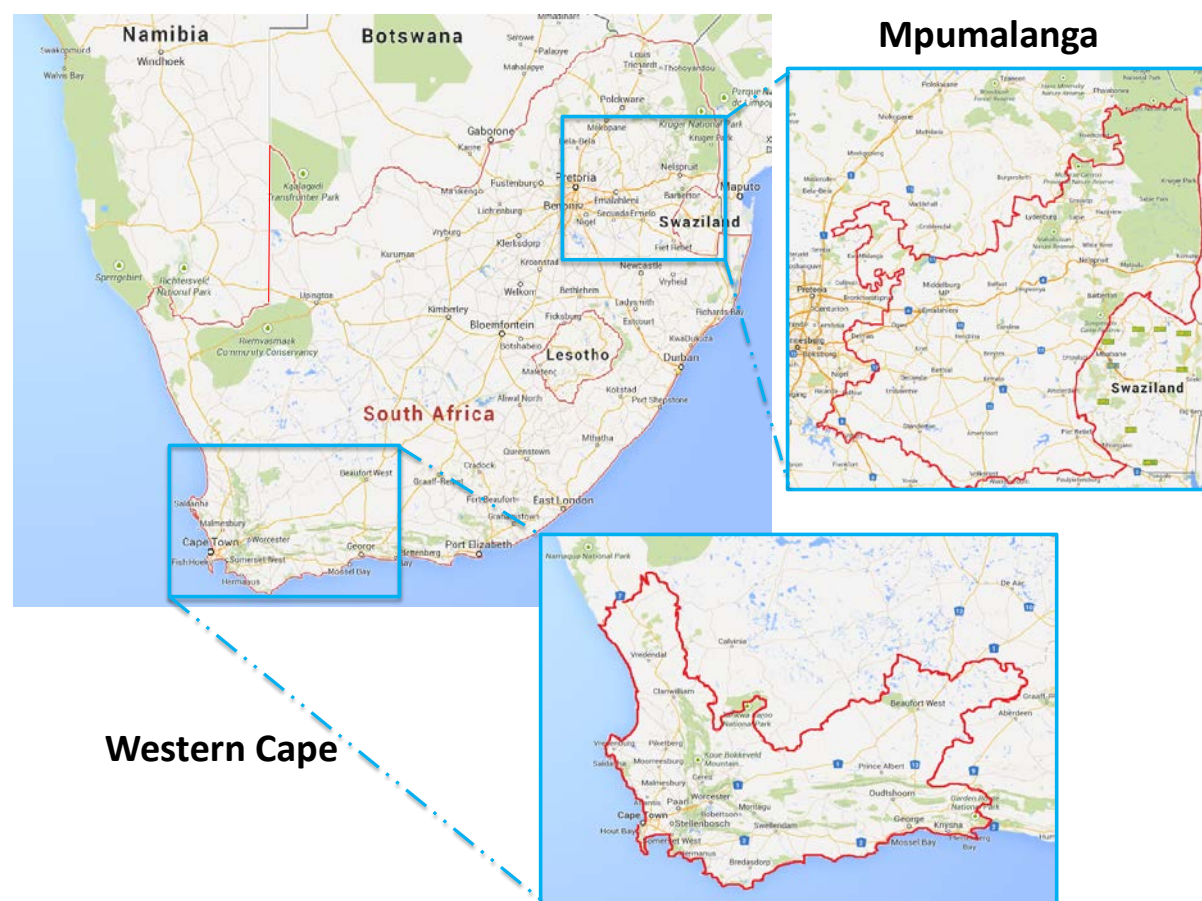


Figure 1-2: Map of South Africa indicating the fieldwork sites

1.2.1 Research Setting

The study took place in South Africa (**Figure 1-2**), in the Western Cape and Mpumalanga provinces. These provinces were selected for epidemiological and pragmatic reasons.

Mpumalanga is in the northeast of South Africa, bordering Mozambique and Swaziland. The population of Mpumalanga is mainly Black; of Swazi, Tsonga and Northern Sotho ethnicity; and Swati, Tsonga and Sepedi language. Mpumalanga has previously been under-researched, and government officials had urged for research to occur there. The research sites in Mpumalanga were black townships and former homelands around both the rural Bushbuckridge and the urban Mbombela municipality. Both are situated in Ehlanzeni District (Figure 1-3), which has an antenatal HIV prevalence of 33.1% (Department of Health, 2010).

Prior to the end of Apartheid, this area was known as the Eastern Transvaal und included the homelands of Lebowa, Gazankulu and KaNgwane (Department of Agriculture, 2010), where black citizens were re-settled due to segregation policies (King & McCusker, 2007).



Figure 1-3: Ehlanzeni District, Mpumalanga

HIV prevalence in Mpumalanga is estimated to be 35.1% in pregnant women (Department of Health, 2010). In 2009, there were estimated to be 183,000 maternally orphaned children living in Mpumalanga province, about 150,000 of whom were orphaned by AIDS (ASSA, 2006). This indicates that approximately 16.7% of the child population are orphaned (Statistics SA, 2012b). Educational achievement in Mpumalanga is low. Approximately 50% of learners do not reach grade 12 and 35.2% of students who sit the National Senior Certificate examination (A-levels) fail to pass (Department of Basic Education, 2013). Only 1.8% of Grade 9 learners achieve

acceptable levels (50%) in mathematics, and 19.3% achieve acceptable grades for their first additional language which is generally English (Department of Basic Education, 2012).

The Western Cape is situated on the west coast of South Africa. The black population consists mainly of Xhosa ethnicity and Xhosa language. The research sites in the Western Cape were black townships in the urban Cape Flats and in the rural Grabouw area. Due to ongoing riots and unsafe fieldwork conditions, the rural site was then moved to Stellenbosch (Figure 1-4). The Cape Flats are a flat area situated southeast of the central business district of Cape Town, which became home to the non-white population during Apartheid, many of whom lived in informal settlements (Standing, 2005). The Flats are home to two of the city's largest townships: Khayelitsha and Gugulethu.

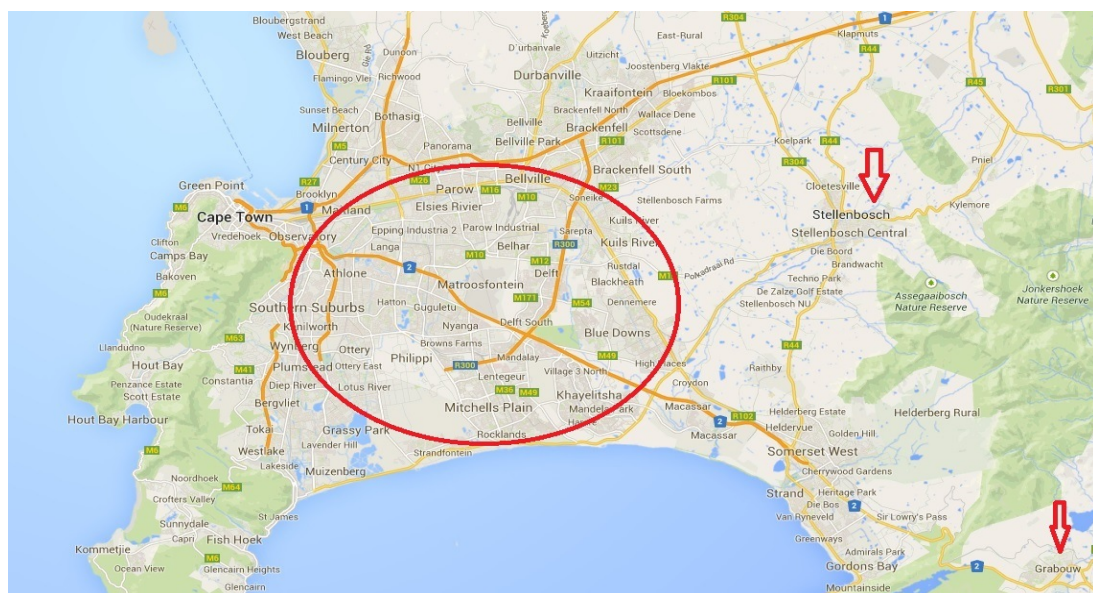


Figure 1-4: Western Cape fieldwork sites

The province's HIV prevalence rate overall is an estimated 18.5% in pregnant women (Department of Health, 2010). However, HIV prevalence is affected by Apartheid population planning which led to segregated communities of White, Coloured and Black South Africans. White and Coloured South Africans show low HIV-prevalence (estimates around 3-5%) (Western Cape Department of Health, 2007). Black urban and rural areas show ante-natal prevalence rates of 30-38% (Department of Health, 2008). In addition, in 2009, there were an

estimated 90,000 maternally orphaned children living in Western Cape townships, 45,000 of whom were orphaned by AIDS (ASSA, 2006). This means that approximately 8.2% of the child population are orphaned (Statistics SA, 2012b).

Compared to Mpumalanga, only a small number of high school leavers fail their final examinations (17.1%), however, 33% do not reach grade 12. Only 7.2% of Grade 9 learners achieve acceptable grades (above 50%) in mathematics, and only 29.2% achieve acceptable marks in their first additional language (Department of Basic Education, 2012).

Even though both provinces have similar levels of HIV prevalence in the black population, they differ in ethnicity, language, culture, and access to antiretroviral (ARVs) and other medical services. In Mpumalanga, only 20% of the population eligible for HAART (highly active antiretroviral therapy) had access to it in 2008. The Western Cape, on the other hand, could provide HAART to 72.7% of eligible people (Adam & Johnson, 2009). There are also significant differences in education. While 2.7% of the population aged over 20 had received no schooling in the Western Cape, 14% had received no schooling in Mpumalanga. Unemployment differs across both provinces. In the Western Cape 21.4% of the population are unemployed, whereas Mpumalanga has an unemployment rate of 31.9%. Infrastructure also differs in both provinces. In the Western Cape, only 1% of the population cannot access piped water, while this is true for 12.6% of households in Mpumalanga (Statistics SA, 2012a).

1.2.2 Sampling

Sampling took place in areas of high financial and health deprivation. These areas tend to also have high HIV incidence, and low literacy. People in these areas do not benefit from health, educational or social services due to weaknesses in infrastructure. Sampling was therefore constructed specifically to enable data collection in these types of communities.

1.2.2.1 Sampling procedure

In the Western Cape and Mpumalanga, four health districts with an HIV prevalence of 30% or higher were selected using ante-natal data (Day & Gray, 2008). As prevalence figures were available by health district, qualifying districts were categorized as either rural or urban, and one was chosen randomly from each group in each province. Within each health district, sequentially numbered census enumeration areas were selected by random number generation until the required sample size was reached. All households in the selected enumeration areas were sampled by interviewers who walked from door to door, explaining the project and asking a number of qualifying questions (see next section).

1.2.2.2 Household Sampling Process

Both households with healthy carers and with ill carers were included in the sample. The fieldworker would then interview one child who was randomly selected from the qualifying household. To determine qualifying households in the enumeration areas and sample group status of the participants, the following questions were asked during the sampling process **(Error! Reference source not found.)**.

It was problematic to determine what constituted a household in some areas given that a number of members of one family were living in separate houses or shacks on one piece of land. These households shared caring responsibilities for children and adults, shared facilities or worked together. In order to avoid accidentally sampling two members of one household, a household unit was defined as a group of people cooking for or with each other (Statistics SA, 1998).

All of the children interviewed at baseline were traced, and if found, re-interviewed at follow-up (96.8% retention rate).

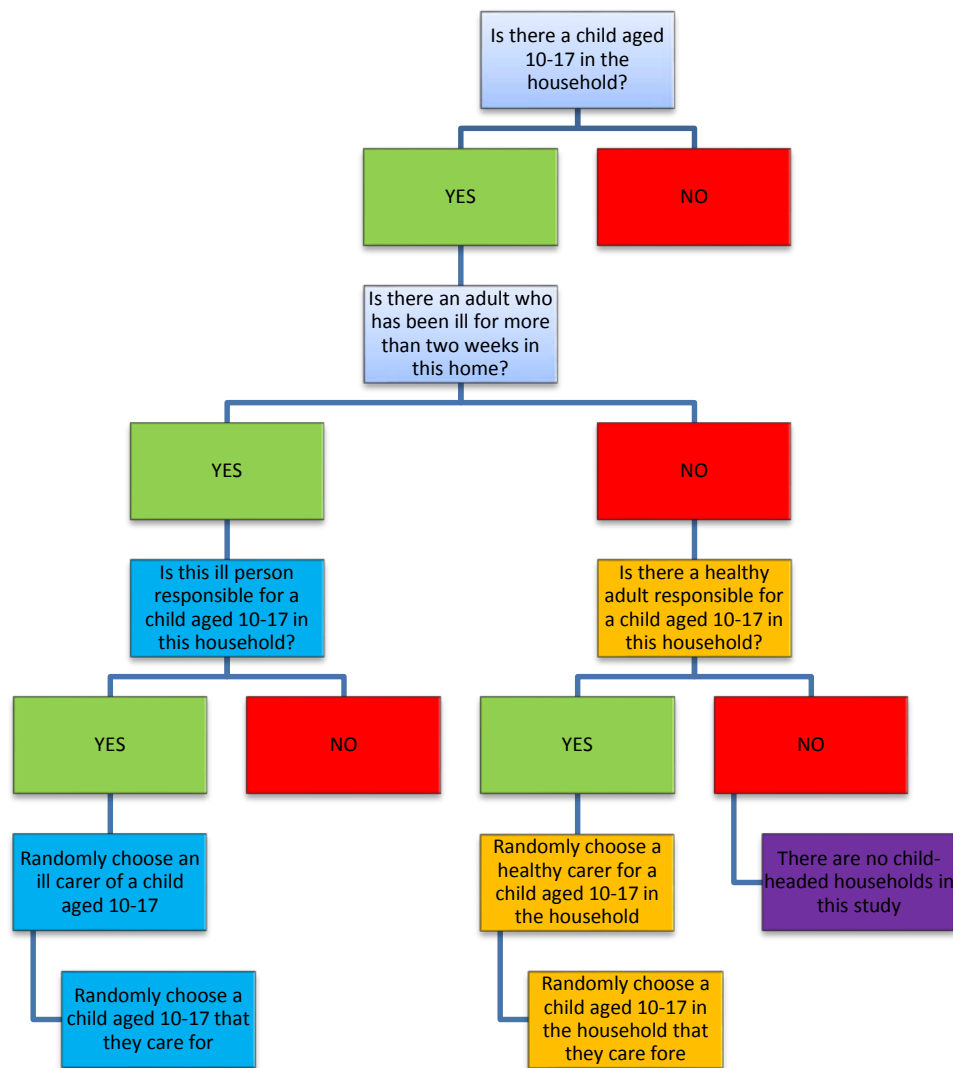


Figure 1-5: Sampling procedure

1.2.3 Ethical considerations

1.2.3.1 Ethical approval

Ethical approval for ‘Young Carers’ was sought from the University of Oxford, the University of Cape Town, and the University of KwaZulu-Natal. The provincial Health and Education Departments in Mpumalanga, KwaZulu-Natal and the Western Cape also gave ethical clearance. Further clearance was granted by all of the above organisations regarding additional items for the second round of data collection, all of which were pre-piloted with social workers and vulnerable children (ethical protocols can be found in Appendix 1, ethical approvals in Appendix 2).

1.2.3.2 Informed-Consent from children and caregivers

First, this study sought caregiver consent for all children participating in the survey. Caregiver consent was sought by providing caregivers with a consent form explaining the purpose of the research. In addition, all ethical information was explained verbally at the time of recruitment by the research assistants in the language of the caregiver. In situations where no adult caregiver was identified, children were asked to name an adult close to them who could give consent for participation in the study (i.e., an older sibling or a teacher). In situations where it was clear that caregiver consent was being refused due to abuse, illegal activities in the home or difficult home circumstances, approval was granted by the local ethics boards that allowed children to appoint another adult who could then be approached for consent. This happened in only two cases in which children lived in households that traded illegal substances (consent forms can be found in Appendix 3).

In addition, all children who participated in this study gave consent at both baseline and follow-up. Child respondents were provided with easily understandable and simple consent forms in their local language. In light of low literacy levels in the regions, all consent forms were also explained by the research assistants. Verbal agreement was obtained in addition to written consent.

Research assistants explained to the children in their mother tongue that they could refuse to participate in the research at any time and without stating a reason. Children who stopped the interview were still given a certificate and cookies, and they were thanked for their participation.

All children who participated in the study received a leaflet with contact information for available services such as reproductive health, child abuse, mental health, etc. In addition, children were provided with a participation certificate. Contact information for the staff and the Principal Investigator (PI) as well as details on how to make a complaint were located on the

back of this certificate. Telephone numbers were also provided for ethical committees and child helplines (certificates can be found in Appendix 4).

1.2.3.3 Confidentiality

All data collected during this survey were treated as confidential. Research assistants were trained to ensure that the interviews took place in a confidential environment. Where it was difficult to find private space, interviewers were asked to consider interviewing children in schools, vegetable patches or in the shade under trees always ensuring that bystanders could not overhear what was said during the interview. Many children opted to be interviewed at school or at the public library, and interviewers facilitated the children's preferences as much as possible.

To ensure anonymity, a child's responses were not linked to his/her name. Highly confidential data, such as those regarding abuse, sexual health and illness in the household, were kept in unmarked envelopes separate from the rest of the questionnaire to protect all participants.

1.2.3.4 Risk of significant harm and referrals

As children were asked about their abuse experience, many disclosed household situations that had the potential for significant harm. As part of the consent procedure, research assistants explained to the children that all information was confidential apart from disclosures that, at the interviewer's or project manager's evaluation, put the child at risk of significant harm. In these cases, the interviewer discussed the case with the project manager who then went to meet the child to discuss referral to health or social services in more detail. In all cases where the child agreed to a referral, the interviewer and/or the project manager accompanied the child to see the social worker or go to the clinic. Where a child was suffering from suicide ideation, the project manager wrote a referral to the local clinical psychologist for counselling. Where children agreed for their caregivers to be informed of out of home abuse situations, caregivers

were notified by both the interviewers and the project manager. Referral options were then discussed with the caregiver and child (examples of referral letters are found in Appendix 5).

In cases where the child did not consent and the threshold of significant harm was not thought to have been met, children were encouraged to call Childline by themselves or with the help of an interviewer and were provided with information on how to self-refer to the appropriate agencies.

Where children refused to consent to disclosure and the threshold for significant harm to a child was met (n=3), the project manager and interviewers continued to consult with each other and with the child. Once they had earned the child's trust and an appropriate support plan had been implemented, the child agreed to a referral. Referral procedures were in line with guidelines for ethical research involving children (Radford, 2013).

The majority of referrals were made for severe poverty (more than 5 days in the past week without food), severe suicide ideation, severe ongoing physical or emotional abuse, severe medical neglect (where children were very ill and had not been taken to see a health professional), rape victimisation within the past 72 hours, and ongoing regular sexual abuse victimisation within the household. A total of 664 referrals to social and health services were made during follow-up data collection in both provinces.

1.2.3.5 Stigma

In order to protect participants from AIDS-related stigma, HIV/AIDS was not mentioned on any of the certificates, consent forms or information sheets. AIDS-related stigma can lead to bullying, denial of support and gossip within the community. In addition, HIV/AIDS-related variables in the dataset were encoded to protect participants from involuntary disclosure.

1.2.3.6 *Giving back to the community*

The whole research project was carried out with support from local communities. Once enumeration areas had been identified, the project manager and research assistants met with local Indunas (chieftains) and politicians and attended community meetings to present the project and answer questions. At the end of baseline data collection, feedback leaflets were issued to the community and community leaders as soon as results were available. These were written in simple language to make it understandable for groups with low literacy. They contained information about the project's findings and progress. Community leaflets did not include references about highly sensitive topics such as HIV/AIDS. Feedback forms included information on positive as well as negative findings. Children also received a child-friendly version of the findings. In addition, the project manager and interviewers attended community meetings to talk about the research findings and inform community members about follow-up data collection. At the end of the follow-up data collection, all communities were visited again to disseminate final research findings (see list in Appendix 6).

In addition, study participants received help with applying for grants and obtaining birth certificates or other official documentation as well as help with referrals to other services if deemed necessary.

A final results report was also compiled and presented to members of the Mpumalanga provincial government in Nelspruit (see Appendix 7).

1.2.4 Interviewers

Some interviewers for this project were recruited from a previous project on vulnerable children in Cape Town while others were recruited through the Rural AIDS and Development Action Research Programme (RADAR), based at the rural facility of the University of the Witwatersrand in Mpumalanga. When necessary, other interviewers were recruited by the project manager during the course of the research. All interviewers were multi-lingual and

spoke at least two local languages in addition to English. All members of staff had project contracts.

All interviewers employed by this study had previous experience in working with vulnerable children and children affected by HIV/AIDS. All interviewers received additional training in administering the questionnaire and in interacting with vulnerable children prior to the commencement of data collection.

In order to ensure quality control and identify further training needs, the project manager made regular unannounced visits to the sites to observe the interview process. Weekly staff meetings were held to encourage staff feedback regarding identified training needs or problems with data collection. Training and development exercises were discussed with the PI, and individual plans and discussions were held with each staff member to assist in their individual development.

All questionnaires were checked for completeness and accuracy, and staff members had to return to specific households where data were incomplete. Data were then captured by two members of staff using SPSS. All electronic data were stored on a password-protected computer. All questionnaires were kept in a locked wardrobe in the project manager's house and were delivered to the PI's house for transfer to the UK upon completion of the project.

1.2.5 Measures

Items from standardised questionnaires validated for similar populations were used for child self-report. The questionnaires were administered by a team of trained and experienced field workers. Due to lack of validated scales in South Africa, items which had not been used in previous research were piloted with vulnerable children, their families and social workers before the start of the actual study. This process established their relevance for the target population. The majority of scales, although not officially validated, had been used successfully

in previous studies with vulnerable children in the Western Cape (Cluver, Gardner, & Operario, 2008).

To measure child abuse, a variety of measures were examined. Items of the UNICEF Measures for National-level Monitoring of OVC (Snider & Dawes, 2006) had already been used to measure physical and emotional abuse at baseline and we therefore continued to use as many items as were available for the follow-up to keep outcomes comparable. Furthermore this measure had been previously used in another of our studies with good reliability (Meinck et al., 2013). The ICAST (Zolotor et al., 2009) was rejected because it had too many items which could not be included in the study due to lack of space. The manual did not clarify that users could shorten and adapt it to their needs. The Child Maltreatment Interview Schedule (Briere, 2003), Child Trauma Questionnaire (JTQ) (Bernstein & Fink, 1997) and Juvenile Victimization Questionnaire (JVQ) (Finkelhor et al., 2005) were also reviewed, particularly for the sexual abuse items. Out of these, the JVQ was the most commonly used measure and could be used to capture current child abuse. Therefore five items from the JVQ were adapted and included in the measure.

Children completed face-to-face one-hour interviews in the language of their choice. The survey assessed psychological health (i.e., depression, anxiety, behavioural problems, PTSD), physical health (i.e., nutrition, upper respiratory tract infections), education (i.e., school enrolment, attendance, performance), and social and family functioning (i.e., peer relationships, family functioning, abuse, domestic violence).

1.2.6 Questionnaires

All questionnaires were read to the children by the interviewers. In order to maintain the children's interest and attention, the questionnaire was designed in such way that children enjoyed looking at it (see Appendix 8 for questionnaires).

The questionnaire was designed by Kerry Mauchline and the team using Adobe InDesign. Quotations of famous politicians such as Nelson Mandela and images of popular icons, cartoons and pictures of contemporary life in South African townships were added to retain the interest of the participants. The questionnaire was named Teen Talk 2 and featured a teen-magazine style cover and text design, determined through a pilot process. All questionnaire drafts were reviewed by the teams of interviewers to ensure that questions were accessible and laid out clearly. Sensitive questions such as those concerning abuse or sexual behaviour were embedded between more enjoyable questions such as those about friends, family support or plans for the future. Wherever possible, the questionnaire provided space for the children to draw or write (e.g., a drawing of their house or a message to their deceased family members).

All survey materials (i.e., consent forms, questionnaires and information sheets) were translated into local languages Xhosa (Western Cape), Tsonga, Zulu, Sepedi, Sesotho and Swati (Mpumalanga) by experts in each language. All questionnaires were back-translated and re-checked for translation errors and cultural sensitivity. A group of native speakers then checked spelling, grammar and cohesion.

All scales, apart from the abuse scale, had been used previously with orphans and vulnerable children in South Africa (Cluver & Orkin, 2009).

1.2.7 Research Constraints

1.2.7.1 Crime

Data collection occurred after sunrise and before sunset. Settlements in highly deprived areas were potentially dangerous for research staff, particularly if the areas were unknown to them. The rates for robberies and other contact crimes were reported to be high in South Africa and staff were not put at risk (South African Police Service, 2010). When staff entered a new area, they generally reported back to project management whether they felt safe or not. If staff felt unsafe, it was arranged for interviewers to be in the field in groups. If there were additional

concerns, a community guide who was known and respected in the area was hired for support and additional safety. No break-ins or thefts occurred in the field, and no car-jackings or drug-related violence placed practical limitations on data collection.

All staff members were advised never to transport strangers or stop for strangers while travelling by car. Any concerns that arose while sampling households involved in illegal activities were raised with the project manager. A health and safety fieldwork guide was assembled for staff to ensure that all their safety needs were met (see Appendix 9).

1.2.7.2 Local customs

Transparency and close co-operation with local communities were required. Community meetings were held in all areas where research took place to inform the local population about the research project and answer the community's questions. In addition, school principals were informed of the project. Where given permission, research assistants interviewed children at school, guaranteeing a safe environment and the teaching staff's support. Some groups were afraid research staff might use their acquired knowledge to harm the local population. In one instance, data collection was temporarily restricted by local customs and beliefs. In particular, one village thought that interviewers had come to find out details about children to then kidnap them and recruit them into a Satanist cult. In order to diffuse these rumours, consultations were held with the team and the communities involved. Project managers and interviewers attended several meetings with community leaders and the communities, prayed in front of the communities and wore Christian symbols to demonstrate that there was no threat to the participants.

1.2.7.3 Violence

South Africa is subject to taxi riots, general strikes and political tensions. Service delivery protests occurred in data collection areas on several occasions. Local research assistants were

consulted to assess the situation, and fieldwork was halted to ensure the staff's safety. All members of the team carried rape alarms and mobile phones in order to facilitate contact.

Water protest: nine arrested in Bushbuckridge, South Africa

by Admin on May 8, 2012 in WATER, water and conflict, WATER CONSERVATION, water crisis, water pollution, water quality management, water quality South Africa, WATER SAVING, water storage, WATER SYSTEMS, WATER TANK, water tank dealers, WATER TANK PRICES, water tanks



Nine people were arrested during a service delivery protest over municipal water in Lilydale in the Bushbuckridge municipality on Monday, Mpumalanga police said.

"At 6am residents... went on the rampage. They burnt municipal offices and a Caterpillar grader," said Lt-Col Leonard Hlathi.

The residents were demonstrating their dissatisfaction over municipal water in the area which was unfit for consumption.

Earlier, Water Affairs Minister Edna Molewa released the 2012 Blue Drop Report, warning that the water of 14 municipalities, including Bushbuckridge, did not meet government standards.



Residents were advised to treat the water, through boiling or the use of bleach, before drinking it.

Hlathi said the situation remained tense and police would continue to monitor the area.

The nine people arrested would appear soon in Bushbuckridge Magistrate's Court on charges of public violence and arson.

Source: Jacaranda FM , 08/05/2012

1.2.7.4 Infrastructure constraints

Blackouts and telecommunications problems (i.e., disruption of internet connections) severely limited online communication and data input. Mobile phone services, in particular, were unreliable, and most members of staff carried two phones with different providers. In addition, fieldwork was temporarily suspended when petrol stations ran out of gas due to strikes.

July 14, 2011 11:14 am

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South African petrol stations close as strikes hit

By Andrew England in Johannesburg

South Africa has begun to feel the pinch of industrial action by tens of thousands of workers with reports on Thursday that the strikes have caused at least 250 petrol stations to run out of fuel.

Reggie Sibaya, chief executive of the Fuel Retailers' Association, said 200 stations had closed in Gauteng Province, which hosts the commercial and political capitals of Johannesburg and Pretoria, and another 50 had shut in KwaZulu Natal, the country's most populous province.

"Nationally we have 4,800 service

Editor's choice

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Libyan spokesman: 'We will die for oil'

Source: Financial Times, 14/07/2011

For a week in April 2012, severe floods limited access to data collection areas and prevented staff from getting to work. Bridges and roads were completely destroyed, and data collection was halted until staff were able to access the work areas safely.

Six dead in Mpumalanga floods

January 23 2012 at 02:31pm

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Six people were killed in the floods that ravaged parts of Mpumalanga last week, the provincial co-operative governance department said on Monday.

It was initially reported that two people were killed after a provincial joint operation committee was established on January 18 to compile a comprehensive assessment report on the natural disaster.

But that number had since increased to six, spokesman Simphiwe Kunene in a statement.

The affected areas included the Mkomazi, Bushbuckridge, Thabachweu, Mbombela, and Umjindi municipalities.

The floods were a result of heavy rains that affected river flows and dam levels leading to the closure of low lying bridges and roads and localised flooding.

Kunene said water levels in the province's rivers and dams had since decreased. However, communities were still warned that these remained extremely dangerous and that they should avoid crossing them.

"Relief aid in the form of food parcels, blankets, and tents have been delivered to all affected households within the Ehlanzeni District. Water tankers are supplying water to areas where water supply is interrupted.

"To improve drinking water safety residents have also been supplied with chloro floc sachets to purify the water. Residents are informed that this water is for free and they must not be made to pay for it," Kunene warned.



Access road to AFB Hoedspruit. Photo: Maj G Van Staden

Source: Independent online (IOL), 23/01/2011

Wild animals, such as elephants from the adjacent Kruger National Park, roamed the communities on occasion and were a potential danger to staff. Whenever sightings were reported, all interviewers were instructed to move to a different area and continue work from there.

Villagers hurt in frenzy for dead elephants' meat

Residents blamed for jumbos' escape

RIOT HLATSHWAYO and ZINKIE SITHOLE

At least three people were injured when villagers swarmed on the carcasses of six elephants that were gunned down after they escaped from the Kruger National Park.

Rangers shot the elephants after the jumbos travelled 30km from the park, through the densely-populated Mkhulu area, to Cunningham's B village.

The carcasses were then left for residents to butcher.

"Some people had to receive medical treatment after being accidentally hacked with axes, pangas and butcher knives when the elephants were being cut," said Sesana Ubisi (55) from neighbouring Kidare village this week.

She admitted she also rushed to the scene to get her share of what she called "Christmas meat", and on her arrival she found a bloody mess.

"There was blood everywhere and people were still carrying meat in bags, basins and buckets, and in the back of bakkies," she said.

She found one man bleeding from his right arm. He told her that he and two others had been accidentally chopped in the frenzy to get to the meat.

Another resident, Jabulani Mathimbi, said he was deeply moved when he saw the elephants being killed.

He said one of the jumbos stood back on its hind legs and trumpeted in pain before collapsing backwards and dying.

"When its trunk faced the heavens and it made a sound of pain, I really felt pity," said Mathimbi.

A teacher at the local Jan Rikhotso Primary School, Luther Ubisi, was one of those who helped conservation officials load the elephants' heads and legs onto the back of a truck and bakkie.

"They were really heavy. We were covered in blood," said Ubisi.

Source: City Press, 18/09/2011

1.2.7.5 Tracing constraints

Between baseline and follow-up, a number of children moved away from the location of the initial interview. Some had moved to different towns and provinces. Two moved out of the country, to Mozambique and Swaziland. The moves made it difficult to trace children, particularly where the whole family had moved and neighbours were not aware of their destination. In Mpumalanga, almost 99% of children were traced and re-interviewed. Eight children refused participation at follow-up, and ten children could not be found. In the Western Cape, approximately 100 children could not be found (96% retention rate). Most of these children had moved to the Eastern Cape but could not be traced. Interviewers travelled to Swaziland, Mozambique and seven provinces within South Africa to re-interview the children who they were able to contact. Children were only declared lost to follow-up if interviewers were unable to locate the child or if interviewing the child required extraordinary expenditure.

1.3 Research objective aims and research questions

The aim of this thesis is to increase the evidence-base with regard to physical, emotional and sexual child abuse victimisation in South Africa. It seeks to further our understanding of the scope of the problem as well as the underlying and interlinking factors which put children at risk of abuse. To achieve this goal, the thesis is guided by research questions which evolved from the systematic review (Meinck, Cluver, Boyes, & Mhlongo, 2014). These research questions can be divided into three different categories:

1.3.1 Systematic review of existing research

1. What are prevalence rates of physical, emotional and sexual child abuse in Africa?
2. What are risk factors or correlates of physical, emotional and sexual child abuse victimisation in Africa?
3. What are the limitations to existing evidence on child abuse risk factors in South Africa?

1.3.2 The nature and extent of child abuse in South Africa

4. What are prevalence, incidence, perpetrators and locations of physical, emotional and sexual child abuse?

1.3.3 Risk factors for child abuse victimisation in South Africa

5. Are there any direct effects of household illness (AIDS and other) on physical and emotional child abuse?

6. Is the relationship between household illness and abuse mediated by the extent of the ill person's disability or by poverty?

7. What are risk and protective factors for child sexual abuse victimisation?

8. Are protective factors also possible moderators of the relationship between risk factors and child sexual abuse victimisation?

This study did not seek to investigate Munchausen syndrome by proxy (MSBP), which involves the fabrication of an illness by the caregiver in the child (Rosenberg, 1987). MSPB was excluded due to a lack of studies from the African region and limitations in their design. The few studies available were individual patient case reports (Croft & Jervis, 1989; Ifere, Yakubu, Aikhionbare, Quaitey, & Taqi, 1993). Neglect was not investigated due to the difficulty of measuring and distinguishing neglect in areas of extreme deprivation as the two co-occur frequently (Slack, Holl, McDaniel, Yoo, & Bolger, 2004).

1.4 Thesis organisation/structure

This thesis is composed of four stand-alone papers which all link together. The four papers include a systematic review of the literature, followed by three empirical papers based on data from the longitudinal study as described above. There was no explicit guidance available from the University of Oxford regarding the structure of DPhils by stand-alone papers. Therefore,

the following format was chosen: Each paper is presented in a format suitable for submission to a peer-reviewed journal with all but one paper currently under review. A title page for each article is followed by an abstract, an introduction, a methods and results section, and a discussion. Tables and figures are embedded in the text wherever possible to facilitate reading. All four papers are connected through linking paragraphs.

The systematic review (research questions 1-3) reports on all retrievable studies carried out on the African continent that investigated correlates of physical, emotional or sexual child abuse. It summarises prevalence rates, methodology and correlates. The existing literature was critically appraised, and the review highlights methodological shortcomings, research gaps and the validity of findings. The findings from the systematic review were used to inform and design the longitudinal study and the resulting papers.

The second paper (research question 4) investigates incidence, prevalence, perpetrators and locations of physical, emotional and sexual abuse as well as multiple abuse victimisation. The third paper (research questions 5 and 6) investigates the relationship between chronic household illness and physical and emotional abuse through multiple mediation analyses with disability and poverty as hypothesised mediators. The final paper (research question 7 and 8) investigates predictors for contact sexual abuse victimisation and the role of peer support as a protective factor.

At the end of this thesis, the cumulative findings of all four papers are discussed within the context of existing literature in a final discussion section. The study's strengths and limitations, implications for policy and practice as well as directions for future research and plans for disseminating findings follow.

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2 - Paper #1: Correlates of physical, emotional and sexual child abuse victimisation in Africa – A review and implications for practice

Published March 2014, Trauma, Violence & Abuse



Picture: Khayelitsha Township, Cape Town, urban area in the Western Cape

This paper is a systematic review that addresses the study questions one to three on existing evidence with regards to physical, emotional and sexual child abuse victimisation in South Africa. The introduction details the review's context and importance. It then discusses the definitions and parameters of the review, the protocol used for the search strategy, and inclusion and exclusion criteria for the studies found. Results are then described in four sections. Section one details the findings of qualitative studies on risk and protective factors for child abuse victimisation. Section two describes the number and characteristics of the included quantitative studies. Section three examines the prevalence rates for physical, emotional and sexual child abuse victimisation as well as multiple abuse victimisation found in these studies. Section four illustrates the numbers and types of correlates found in the included studies for physical, emotional, sexual and multiple abuse victimisation. The risk factors for each type of abuse are

categorised according to their Ecological Framework level. Following a summary of correlates for each abuse type, critical appraisal of the studies is executed. The discussion section summarises the results and puts them in context with current available evidence on correlates of child abuse and prevalence rates. Limitations of the review are discussed as well as implications for research, policy and practice.

Which research questions does this paper answer?

- 1. What are prevalence rates of physical, emotional and sexual child abuse in Africa?**
- 2. What are risk factors or correlates of physical, emotional and sexual child abuse victimisation in Africa?**
- 3. What are the limitations to existing evidence on risk factors for child abuse**

In its accepted version, the reviewers decided to omit emotional abuse. As part of the thesis, emotional abuse is included in the review.

Abstract

There is now conclusive evidence of the major and long-lasting negative effects of physical, emotional and sexual abuse on children. Within Africa, studies consistently report high rates of child abuse, with prevalence as high as 64%. However, to date there has been no review of the factors associated with physical, emotional and sexual child abuse or with multiple abuse victimisation in Africa. This systematic review identified 23 quantitative studies, all of which showed high levels of child abuse in varying samples of children and adults. Although studies were very heterogeneous, a range of correlates of abuse at different levels of the Model of Ecologic Development were identified. These included community-level factors (rural/urban location), household-level factors (poverty, household violence, non-nuclear family), caregiver-level factors (caregiver illness, in particular HIV/AIDS and mental health problems; caregiver changes; family functioning; parenting, caregiver-child relationship, substance abuse) and child-level factors (age, disability, physical health, behaviour, gender, exposure to bullying and sexual violence). These findings identify key associated factors that are potential foci for child abuse prevention interventions. In addition, there is a clear need for further rigorous longitudinal research into predictive factors and culturally relevant interventions.

Keywords: risk factors, correlates, child abuse, sexual abuse, physical abuse, emotional abuse, Africa

2.1 Background

According to estimates by the World Health Organization, 40 million children under 14 are victims of abuse and neglect worldwide each year (World Health Organization, 2006). Within the African continent, all sovereign states are UN Members that have ratified the UN Convention on the Rights of the Child (UNCRC), with the exception of South Sudan and Somalia. The convention grants all children and adolescents protection from harmful influences, abuse and exploitation (UNICEF, 1990).

Evidence from Africa demonstrates high rates of child abuse. These rates vary greatly depending on the populations sampled, the countries where the study took place, and the measurement tools and definitions used. Reported prevalence rates are as high as 64% for physical abuse (Afifi, El-Lawindi, Ahmed, & Basily, 2003) and 83% for emotional abuse (Akmatov, 2011). In the case of sexual abuse, reported rates reach 56% in males and 53% in females (Madu & Peltzer, 2000). The WHO African region also has the highest rates of child homicide for under 5 year olds in the world (World Health Organization, 2002). These prevalence rates are substantially higher than in Western community samples, where they are reported as around 14% for physical abuse, 22% for emotional abuse (Bardi & Borgognini-Tarli, 2001; Cohen et al., 2006; May-Chahal & Cawson, 2005; Radford, Corral, Bradley, & Fisher, 2013) and as high as 45% in females and 19% in males for sexual abuse (Goldman & Padayachi, 1997).

Explanations for the elevated prevalence rates of child abuse on the African continent often lack empirical basis. Hypothesised causes include poverty, large numbers of orphaned children, modernisation and negation of traditional values, disruption of community structures and social norms, corruption, and the adoption of culturally irrelevant and poorly developed child protective systems (Lachman et al., 2002). Qualitative evidence suggests the influence of some cultural or societal factors such as an acceptance or tradition of harsh physical punishment as a means for discipline. This may be particularly present in patriarchal families, where some

studies find that male dominance can include physical punishment or sexual gratification (Richter & Dawes, 2008). Research on social attitudes in South Africa suggests that some cultures report high tolerance for sexual coercion and severe physical punishment of children (Andersson et al., 2004; Peltzer, 1999). Finally, commentators have noted the widely-cited ‘virgin cure’, whereby sex with an infant or young child is said to cure HIV. However, there is a lack of quantitative evidence to test the prevalence of this practice (Jewkes, 2004).

In high income countries, it has been established that experiencing childhood abuse can lead to multiple negative outcomes for the child, including substance abuse (McCord, 1983), risky sexual behaviour (Cunningham, Stiffman, Doré, & Earls, 1994), mental health problems (Glaser, 2002; Mullen, Martin, Anderson, Romans, & Herbison, 1996), increased risk of victimisation (Bowes et al., 2009; Messman-Moore & Long, 2000), poor physical health (Springer, Sheridan, Kuo, & Carnes, 2003) and death (Sidebotham, 2007).

Evidence from Africa demonstrates even stronger linkages and more severe outcomes for child abuse. These outcomes include a greatly increased risk of re-victimisation (Ibanga, 2011; Jewkes, Levin, Mbananga, & Bradshaw, 2002), increased risk of HIV infection, poor physical health (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010; Reza et al., 2009), higher child death rates (Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013) and exposure to transactional sex (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Peltzer & Pengpid, 2008). In addition, there are similar outcomes of abuse as those found in the West such as delinquency, substance abuse (Brown et al., 2009; Jewkes et al., 2006; Morojele & Brook, 2006), depression and suicide (Cluver, Gardner, & Operario, 2009; Fincham, Altes, Stein, & Seedat, 2009; Frank-Briggs & Alikor, 2010; Oladeji, Mkanjoula, & Gureje, 2010; Wondie, Zemene, Tafesse, Reschke, & Schröder, 2011). However, such outcomes may have even more severe consequences for children in Africa due to limited access to mental health and social services (World Health Organization, 2011a).

Child abuse in Africa frequently occurs in a different context from the West due to war, extreme poverty, high levels of HIV, and socio-cultural variations in family structures and attitudes. Thus, it is essential that research on child abuse does not rely on evidence from Western samples but instead empirically tests outcomes of abuse as well as risk and protective factors for abuse within African societies.

Just as prevalence rates and outcomes of abuse may manifest differently in Africa, so too may risk and protective factors. Identifying socio-demographic correlates and risks for abuse is essential to inform preventative evidence-based interventions. Extensive research has examined risk factors in the West (Black, Heyman, & Smith Slep, 2001a, 2001b; Black, Smith Slep, & Heyman, 2001) although research on protective factors remains limited. It is, of course, dangerous to assume transferability from Western studies to Africa.

Family structures in African countries are undergoing change. Key traditional clan practices - corporate kinship and extended families in which families take on childcare responsibilities for relatives or neighbours- are still dominant but there is an ongoing shift towards nuclear households (Lauras Lecoh, 1990). In addition, female single parenthood is becoming very common across sub-Saharan Africa. Female single parents are generally over-represented in the most poverty-stricken groups and have few opportunities for improvement due to societal changes and migration. In South Africa particularly, Apartheid¹ policies led to the disruption of many kinship ties amongst South African families. This resulted in a large number of disadvantaged single-parent families that were often forced to move back home to be supported by grandparents (Preston-Whyte, 1993). In addition, workplace rules restricting children from staying with their working mothers as well as the HIV/AIDS epidemic have led to an increased importance and sometimes overburdening of grandparents taking on parenting roles in many

¹ Apartheid: Former politics of racial segregation in South Africa with political, social and economic discrimination of non-European groups from 1948 until 1993 <http://www.merriam-webster.com/dictionary/Apartheid>

African countries (Beegle, Filmer, Stokes, & Tiererova, 2010). Due to the HIV/AIDS epidemic, large numbers of children are either caring for an ill family member or have been orphaned, are staying with step-parents, relatives or neighbours or in child-headed households. Many of those children are subjected to abuse and exploitation (Morantz et al., 2013).

Studies investigating risk and protective factors for child abuse primarily use Bronfenbrenner's Ecological Model of Human Development (Bronfenbrenner, 1979). This framework places children at the centre of multiple interacting spheres of influence. Closest to the child are relationships with caregivers² and family. More distal are the ways in which child and family are influenced by school, community, society and culture. The cumulative and counter-balancing effects of risk and protective factors within and across spheres, depending on their severity and strength, may lead to or prevent child abuse (Belsky, 1980; World Health Organization, 2002).

This ecological theory provides a valuable framework for examining risk and protective factors for child abuse in Africa. However, few studies examine such factors within the African context, and a comprehensive review of risk and protective factors previously has not been conducted. This review explores individual, parental, household and community correlates of physical and sexual abuse amongst children and adolescents in the African context. As there is limited evidence available, surveys and descriptive studies are included, and selected qualitative research is also reviewed. In addition, this review seeks to build upon and update Lalor's (2004) review of sexual abuse in southern Africa.

It is important to be aware that risk and protective influences on child abuse in Africa take place within varied cultural contexts and highly constrained child protective services. The majority

² The term caregiver refers to the person taking care of a child. It can refer to a parent, family friend, neighbour or other relative. In sub-Saharan Africa, many children are orphaned, have been abandoned by their parents or cannot stay with their parents while they are working. Many children are therefore living in the care of a relative -often aunts and uncles or grandparents- or with neighbours, without formal agreements or legalised transfer of guardianship.

of studies included in this literature review were conducted in South Africa and Egypt. These two countries have vastly different histories, living conditions and demographics. The other studies reviewed were from Mauritania, Nigeria, Zimbabwe and Swaziland (Table 2-1).

Across these countries, child protection systems are vastly different. In Egypt and Mauritania for example, structure and procedures are currently evolving, whereas in countries such as Swaziland, the policy agenda has not prioritised child protection (Human Rights Council, 2010; UNICEF, 2010). In Zimbabwe, the once renowned welfare system collapsed in 2008, with few social workers acting out statutory duties (UNICEF, 2008). Child protective systems in South Africa and Nigeria have been well developed with child protective laws in place (Save the Children, 2011b). However, where child protective systems are available across the continent, they are overburdened by high prevalence of child abuse, lack of staff, limited resources, minimal training and poor co-ordination (Jones, 2011; Lachman, 1996; Lachman et al., 2002; Save the Children, 2011a).

For this review, definitions for physical, emotional and sexual child abuse will be presented first. Secondly, research methods as well as inclusion and exclusion criteria will be explained. Thirdly, qualitative studies exploring factors associated with physical, emotional and sexual abuse will be detailed. Fourth, quantitative studies of correlates of physical, emotional and sexual abuse will be described and appraised, and results will be summarised. Finally, findings and limitations of this review will be discussed alongside implications for practice.

Table 2-1: Country Information

Country	Location	History	Population	Life expectancy	Economic profile	HIV-Prevalence	Orphans
South Africa	Country located in the southern-most tip of Africa, bordering Namibia, Mozambique, Zimbabwe, Botswana, the Indian Ocean and the South Atlantic Ocean	South Africa is a multi-ethnic democracy and former British colony. To this day, South Africa struggles with the remnants of its Apartheid past	51 million, 80% of which are of black African ancestry and predominantly Christian religion. There are approximately 9% Whites and 9% Coloureds as well as 2% Asians within the population. There are an estimated 5 million illegal immigrants in the country (CIA, 2013)	53.4 years (UNDP, 2013)	Upper middle-income country but one of the countries with the highest income inequality with a Gini-coefficient of 63.1 (World Bank, 2010). 13.8% of the population live on less than USD 1.25 a day (UNDP, 2013)	17.3% (UNAIDS, 2012)	3.5 million (UNICEF, 2013)
Egypt	Country on the north-eastern tip of the African continent also comprising a part of the Asian continent, bordering the Mediterranean Sea, Gaza Strip, Israel, Red Sea, Sudan and Libya	Semi-presidential republic and one of the oldest inhabited countries in history. Egypt gained independence from Britain in 1922, first to become a kingdom and then a republic in 1952. There have been ongoing protests since 2011 over legal and political issues calling for reforms (CIA, 2013).	84 million inhabitants, 90% of them of Muslim faith with 10% Coptic and other Christian groups, 99% of the population are Egyptians (CIA, 2013)	73.5 years (UNDP, 2013)	Middle-income country with a Gini-coefficient of 30.8 suggesting medium income inequality (World Bank, 2010). 1.7% of the population live on less than USD 1.25 a day (UNDP, 2013)	No data (UNAIDS, 2012)	1.7 million (UNICEF, 2013)
Mauritania	Country in West Africa bordering the Western Sahara, Algeria, Mali and Senegal as well the Atlantic Ocean	Islamic republic, former French colony in West Africa, ruled by military governments since the 1980s, elected president since 2009 (CIA, 2013)	3.4 million inhabitants, majority of the population depend on agriculture and livestock, nearly 100% of the population are of Muslim faith, population groups are 30% Black, 30% Arab and 40% mixed (CIA, 2013)	59 years (UNDP, 2013)	Low income country with a Gini-coefficient of 40.5 suggesting medium income inequality, 23% of the population live on less than USD 1.25 (UNDP, 2013)	1.1% (UNAIDS, 2012)	170,000 orphaned children (UNAIDS, 2004)
Zimbabwe	Land-locked country surrounded by Botswana, Zambia, and Mozambique	Semi-presidential republic in southern Africa, former British colony which declared independence as Rhodesia in 1965 and became an unrecognised state, since 1980 de jure independence from the UK (CIA, 2013)	12.6 million, 98% of the population are Bantu-speaking ethnic groups, majority follow Christianity (CIA, 2013)	47 years for men and 45 years for women (UNDESA, 2011)	Low income country with a Gini-coefficient of 50.1 showing high income inequality (World Bank, 2010), 72% of the population live under the national poverty line (UNDP, 2013)	15% in the general population (UNAIDS, 2012)	25% of children (UNICEF, 2006)
Swaziland	Land-locked country surrounded by Mozambique and South Africa	Constitutional monarchy in southern Africa, previous British protectorate, independent since 1968	1.3 million, vast majority Swazi, the predominant religion is Christianity (CIA, 2013)	47 years for both males and females	Lower-middle income country with a Gini-coefficient of 51.5 showing high income inequality (World Bank, 2010), 75% of the population work in subsistence	26% in the general population (UNAIDS, 2012)	70,000 (Li, 2005)

					(UNDESA, 2011)	farming and approximately 40% live on less than USD1.25 per day (UNDP, 2013)			
Nigeria	Country in West Africa bordering Benin, Chad, Cameroon and Niger.	Federal constitutional republic and former British colony, gained independence from Britain in 1960s, a civil war following independence killed between 1 and 3 million people, since its independence Nigeria has alternated between democratic and military governments with democratic rule since 1999 (Chapin Metz, 2008)	7 th most populous country in the world, population of approximately 150 million with over 250 ethnic groups, approximately half of which follow the Muslim and half the Christian faiths, a small minority practices traditional religions (CIA, 2013)	52.3 years (UNDP, 2013)		Middle-income country with a Gini-coefficient of 48.8 showing high income inequality, 68% of the population live on less than USD1.25 per day (UNDP, 2013)	3.7% (UNAIDS, 2012)	8.6 million (UNAIDS, 2004)	

2.2 Objectives

The primary objectives of the review are to synthesise evidence on the following questions:

- 1) What are the prevalence rates for physical, emotional and sexual child abuse victimisation in Africa?
- 2) What are the risk factors/correlates for physical, emotional and sexual child abuse victimisation in Africa?
- 3) What are the limitations to existing evidence on risk factors for child abuse victimisation in Africa?

2.3 Definitions and parameters of the review

UNICEF defines childhood as every age under 18 (UNICEF, 1990), whereas the World Health Organization (2002) defines adolescents as young people between ten and 19 years of age. Given a lack of clear boundaries regarding age of transition from childhood to adolescence and use of both terms in the evidence reviewed, these terms will be used interchangeably for the purposes of this paper. To be included in the review, however, studies had to measure abuse of participants before the age of 18.

It is important to note that definitions of child abuse vary between cultures and societies. For example, studies have reported a widespread acceptance for corporal punishment across the African continent as a means of disciplining children in homes and at school (Global Initiative to End All Corporal Punishment of Children, 2005; World Health Organization, 2010) although some states have outlawed this practice in schools (Dawes & Mushwana, 2007; Finkelhor & Korbin, 1988).

Physical abuse of a child is defined as ‘those acts of commission by a caregiver that cause actual physical harm or have the potential form for harm’ (World Health Organization, 2002,

p. 60). This can include being hit with a hand, hit with an object, kicked, shaken, thrown, burned, stabbed or choked by a parent or a caregiver (Kaplan, Pelcovitz, & Labruna, 1999).

Emotional abuse is one of the least studied forms of child abuse. It is very difficult to define emotional abuse, as ways of addressing a child in one culture may be seen as emotionally abusive in another (World Health Organization, 2002). Emotionally abusive interactions are those which are actually or potentially harmful to the child's psychological or emotional health or development (Glaser, 2002), i.e., repeatedly conveying to the child that they are 'worthless, flawed, unloved, unwanted, endangered or of value only in meeting another's needs' (American Professional Society on the Abuse of Children, 1995). Acts of emotional abuse include repeated spurning, terrorising, exploiting, corrupting, insulting, threatening, ignoring or isolating a child. They might also include denying a child emotional responsiveness or failing to ensure the child's mental health and emotional needs are met (Garbarino & Garbarino, 1994). However, it is worth noting that shouting or threatening children are used as common means of discipline across countries (López-Stewart et al., 2000). Emotional abuse has received less attention worldwide than physical or sexual abuse, but evidence suggests similarly negative outcomes for children (Doyle, 1997; Mullen, Martin, Anderson, Romans, & Herbison, 1996).

Sexual abuse is defined as 'the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society' (World Health Organization, 2010, p. 16). This includes any type of inappropriate touching; forced oral, genital or anal penetration; forced exposure of private parts; forced viewing of other people's sexual anatomy or pornography; and sexual harassment by adults, older children or peers who are in a position of power over their victim (World Health Organization, 2010).

Multiple abuse victimisation is defined as experiencing two or more different types of abuse, e.g., emotional and sexual abuse.

Correlates are factors which are shown to be associated with each other, whereas *risk factors* must be correlated with an outcome and must be shown to precede the outcome (Murray, Farrington, & Eisner, 2009).

2.3.1 Protocol

This literature review uses both published and unpublished studies. The Guidelines for Meta-analysis of Observational Studies in Epidemiology (MOOSE) were followed where appropriate (Stroup et al., 2000). Keyword searches were made for the years 1998 to April 2012 in the following electronic databases: Primo Central, PsychINFO, EMBASE, Global Health Medline(r) via Ovid, CINAHL and Family and Society Studies Worldwide via EBSCO, ERIC via CSA Illumina, and British Nursing Index. Grey literature searches were conducted in the Interdisciplinary Dissertation and Thesis Database and Dissertation Abstracts International via ProQuest, Index to Theses and SCIRUS Electronic Thesis Database. Searches were made in the online publications of several organisations (UNICEF, Save the Children, World Health Organization, International Society for the Prevention of Child Abuse and Neglect (ISPCAN), African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN), Childline South Africa, African Network for the Prevention and Protection against Child Abuse and Neglect Uganda (ANPPCANUG), Human and Social Research Council, and Medical Research Council), child abuse conferences and government publications (South Africa, Kenya, Zimbabwe, Uganda, Nigeria). Additionally, studies were located via e-mail requests to academics, web searches (Google, Google Scholar, findarticles.com) and existing reviews (Lalor, 2004). No language restrictions were applied (Figure 2-1).

The following search terms were used in various combinations depending on the requirements of the individual databases:

Child*, adolescent*, boy*, girl*, youth*, young*, teen*, pube*, pre-pube*, minor*, juvenile*, toddler*, infant*

physical, emotional, sexual, psychological, abuse, maltreatment, exploitation, forced sex risk factor*, protective factor*, predictor*, violence, victimization, victimisation

Africa, South Africa, Afrique noire, sub-Saharan Africa, west* Africa, north* Africa, Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Somalia, Tanzania, Uganda, Zambia, Angola, Cameroon, Central African Republic, Chad, Congo, guinea, Gabon, Algeria, Egypt, Libya, Morocco, Sudan, Tunisia, Botswana, Zimbabwe, Swaziland, Lesotho, Namibia, Togo, Sierra Leone, Burkina Faso, Benin, Ivory Coast, Gambia, Ghana, Liberia, Mali, Niger, Nigeria, Senegal, Togo, Mali.

Figure 2-1: Search terms used to identify studies for the review

2.3.2 Inclusion and exclusion criteria

This review focuses on physical, emotional and sexual abuse of adolescents and children. All studies had to be carried out on the African continent. For physical and emotional abuse or harsh abusive parenting, this review was limited to incidents within the home. Studies were included if they measured occurrence of physical abuse defined as hitting a child with an object or hand, leaving marks on a child's body, burning, slapping or stabbing. Studies investigating emotional abuse were included where they measured occurrence of threats, insults, degradation or differential treatment compared to siblings within the household and directed at the child. There are no studies within the African context that investigate sexual abuse within the home alone. Therefore, studies using sexual abuse outcomes, including (but not limited to) sexual harassment, forced intercourse and inappropriate physical contact by any perpetrator, were included in this review.

Following the hierarchy of evidence, the following study designs were eligible for inclusion in the review: systematic reviews or meta-analysis (not available), randomised controlled trials (not available), longitudinal studies (not available), cross-sectional studies, case control studies,

and qualitative studies (Sackett, 1996). Details on the studies excluded and included in the review are compiled in the PRISMA flow chart (see Figure 2-2 based on (Moher, Liberati, Tetzlaff, & Altman, 2009)).

Studies investigating neglect, Munchhausen syndrome by proxy (MSBP), physical victimisation by peers (bullying) or teachers, interpersonal violence, community violence, child labour, child trafficking, child abduction, mental health, substance abuse and delinquency were beyond the scope of this review. However, these are important areas for future research.

2.4 Results

2.4.1 Qualitative studies

Qualitative research can be helpful when investigating perceptions of child abuse (Jewkes, Penn-Kekana, & Rose-Junius, 2005; Ogunyemi, 2000), particularly for in-depth explorations of certain victim or perpetrator groups (Abrahams, Mathews, & Ramela, 2006). Qualitative research can also help to identify barriers to help-seeking behaviour in cases of abuse (Smith, Bryant-Davis, Tillman, & Marks, 2010).

Plummer & Njugana (2009) grouped 36 child protection and police professionals in Kenya by tribal association and asked them to identify cultural risk and protective factors for sexual child abuse. Parental divorce, child homelessness, AIDS orphanhood, patriarchy, a culture of silence, perceived unimportance of children, foreign influences (i.e., internet and pornography), social upheavals and poverty were identified as correlates. Identified protective factors were modesty, family structure, familial guidance and supervision, religion, separation of males and females, valuing children, emphasis on the importance of virginity, and harsh punishment for offenders.

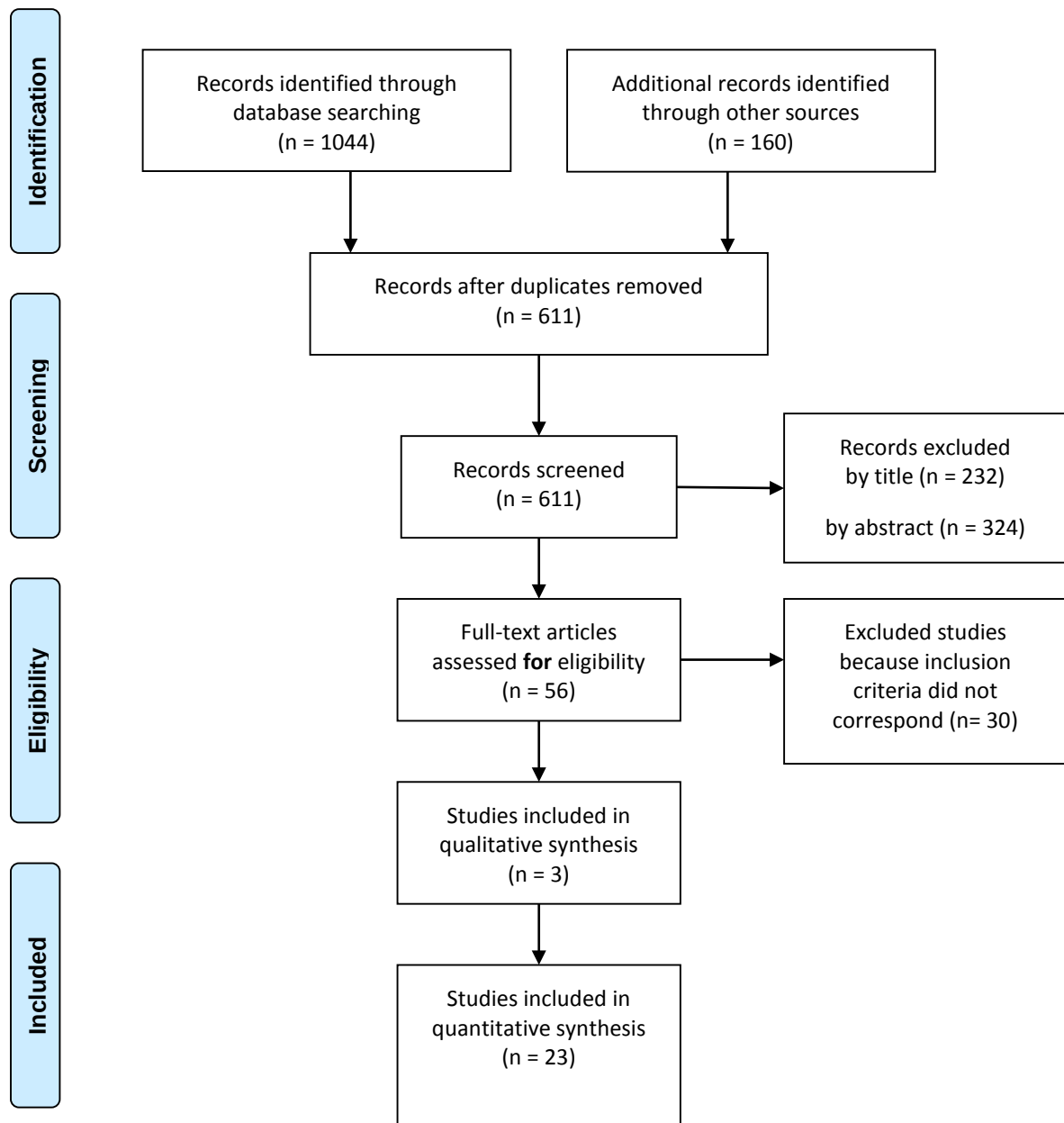


Figure 2-2: Prisma Flow Chart for Literature Search

Makoe, Dawes, Loeffel and Ward (2008) reviewed 150 court files from Children's Court inquiry records, child abuse hotline records of children removed from their parents and data from hospital records. They also undertook qualitative research with social workers and other child protection professionals in South Africa. The primary reasons children were subjected to abuse and were subsequently removed from their parents were found to be alcohol and substance abuse by the primary caregiver. Removal rates were higher for children living in poverty, growing up in single-parent homes, experiencing poor quality of relationships within the home, and whose parents were dealing drugs, engaging in sex work, and criminal activity. Children under the age of four, teenagers, only children and those with incarcerated parents were also more likely to be removed.

In a more broadly focused study on child vulnerability, Giese, Meintjes, Croke and Chamberlain (2003) interviewed 65 orphans and vulnerable children (OVC), 130 caregivers and 80 service providers across South Africa. An emerging theme of this study in particular was the physical and emotional abuse of orphans placed with relatives.

2.4.2 Quantitative studies

There have been relatively few studies investigating correlates of child abuse across the African continent, with the majority of those available focusing on sexual abuse.

Thorough searching revealed a total of 23 quantitative studies investigating correlates of physical, emotional and sexual child abuse. Table 2-2 provides a summary of findings. Sample sizes ranged from 77 to 126,696 respondents. All studies apart from one were published. The vast majority of studies were cross-sectional surveys. Only three studies were based on abuse case files and had no comparison group of non-abused children. In 18 studies, children or adults were interviewed directly regarding their childhood abuse experience, and one study interviewed primary caregivers about corporal punishment used with children. Four studies used incident reports or patient files. Sixteen studies were carried out in South Africa, three in

Egypt, and one in each Nigeria, Zimbabwe, Swaziland and Mauritania. All of the studies used cross-sectional data. Risk factors are therefore associated factors rather than predictors, and causality cannot be assumed (Murray et al., 2009). In addition, included studies used a variety of measures and definitions for child abuse victimisation. The majority used multivariate logistic regressions for their analysis. All studies which reported odds ratios used 95% confidence intervals except for one that used 99% confidence intervals. All correlates tested within the multivariate regression models are listed in Table 2-3. It is important to note that the included studies were highly heterogenic, and it is essential not to assume generalisability of studies across the African continent, given its diverse cultures, societies and economic backgrounds.

Table 2-2: Summary of Findings

Author/Date	Sample Characteristics	Correlates of child abuse
Affi, 2003	555 children aged 12-18 years (mean 15.6)	<i>Physical Abuse:</i> Maternal disinterest, maternal education, injury signs <i>Emotional Abuse</i> Crowding, child illness <i>Sexual Abuse:</i> Child-hyperactivity, child disability, maternal disinterest, wasting, school non-attendance Protective factors: high birth order of child <i>Multiple-victimisation:</i> Parents quarrel with child, paternal illness, maternal illness, maternal cruelty, problems in family, teacher maltreatment, injury signs
Anderson et al., 2008	126,696 male school children aged 10-19 (mean age 15)	Protective Factors: high birth order of child , paternal predominance <i>Sexual Abuse:</i> Living in rural site areas, living in less developed provinces, verbal insults, physical
Audu, et al., 2009	316 employed girls under the age of 18 (mean age 14.9)	<i>Sexual Abuse:</i> Being younger than 12, having more than 2 jobs, working more than 8 hours, having no formal education Protective factors: father's employment as a trader or senior civil servant and mother's employment as senior civil servant
Ballet, et al., 2011	77 female street children (age not reported), recruited at two NGOs	<i>Physical and Emotional Abuse:</i> parents living together, father present in the household, father's employment, mother's employment, living in the city of Nouadhibou Protective factors: absence of father, father employed as soldier, mother unemployed, mother working as prostitute, parents divorced or deceased, living in the city of Nouakchott
Berard et. al, 1999	934 adolescents (15-22 years old)	<i>Sexual Abuse:</i> Living in a non-nuclear family and history of family alcohol abuse
Birdthistle, et al., 2011	1194 (90% female) aged 0-16 years	<i>Sexual Abuse:</i> double, maternal and paternal orphanhood

Breiding, et al.,	1244, 13-24 years females only	<i>Sexual Abuse:</i> Not being close to mother), not attending school, emotional abuse as child, knowledge of other kids who were assaulted, aware of children having sex with teacher, greater number of people live with child)
Carey, et al., 2008	94 (8.25-19 years) Youth Stress Clinic attendees	<i>Sexual Abuse:</i> Female gender, single-parent families, family receiving disability grant also associated with physical and emotional abuse
Cluver, et al., 2011	723 adolescents (mean age 16.9)	<i>Physical Abuse:</i> Caregiver AIDS-Illness, being orphaned by AIDS and living with a caregiver ill with AIDS (dually affected) <i>Emotional Abuse:</i> AIDS-ill caregiver, orphaned by AIDS, dually affected (AIDS-ill caregiver and AIDS-orphaned)
Collings, 1991	326 male psychology students (mean age 19.7 years)	<i>Sexual Abuse:</i> Being of black race, parental punitiveness, parental rejection, raised without father
Collings, 1993	200 children, 2 months to 17 years (mean 7.95 years) referred to Durban Child	<i>Physical Abuse:</i> younger victims, male gender, White race, younger parents, smaller family units, perpetrator biological parent <i>Sexual Abuse:</i> Female gender, coloured background, perpetrator parent or family, large family units, older parents
Collings, 2005	132 male children aged 1-17	<i>Sexual Abuse:</i> Protective factor: Living with at least one biological parent
Dawes, et al., 2005	925 South African families with children under 18	<i>Physical Abuse:</i> younger child age, older parental age, female parent, single and previously married, factors influencing the severity of corporal punishment: attitudes supportive of corporal punishment and attitudes towards non-empathic parenting
Ibrahim, et al., 2008	1897 female university students aged 18-24	<i>Physical Abuse:</i> Mother's education less than university, domestic violence <i>Emotional Abuse:</i> Domestic violence, parental mental health problems <i>Sexual Abuse:</i> Mother's education less than university, domestic violence, parent's drug addiction, parents not living together <i>Multiple victimisation:</i> mother's education less than university, domestic violence, parental mental health problems, parents not living together
Jewkes, et al., 2002	11 735 women aged 15-49 years	<i>Sexual Abuse:</i> Age-cohort, living in the Western Cape After adjusting for age and province: White
King, et al., 2004	939 aged 12-18 in grades 8 and 11 of high schools (mean 15.7 years)	<i>Sexual Abuse:</i> Risk factors for girls: being female, raised with biological parent and step-parent, single parent, antisocial behaviour, having consumed alcohol, suicidal behaviour Risk factors for boys: living with biological parent and step parent
Madu, 2003	722 undergraduate psychology students aged 15-47 (23.8 years)	<i>Emotional Abuse:</i> Living with stepfather or adoptive father before age 16 <i>Sexual Abuse:</i> Living with a step-father before the age of 16 Protective factor: living with the biological mother before the age of 16
Madu, et al., 2003	722 undergraduate psychology students aged 15-47 (mean age 23.8 years)	<i>Physical Abuse:</i> Domestic violence, parental mental health problems <i>Emotional Abuse</i> Domestic Violence <i>Sexual Abuse:</i> Parental mental health problems, parental drug and alcohol abuse
Madu, et al., 2002	559 grade 9 & 10 high school students aged 11-28 (mean age 17.4)	<i>Physical Abuse:</i> caregiver drug or alcohol abuse, witnessing domestic violence <i>Emotional Abuse</i> Caregiver mental health problems, domestic violence

Madu, et al., 2000	414 secondary school students in grade 9 and 10 aged 14-30 (mean age 18.5 years)	<i>Sexual Abuse:</i> Domestic violence, parental mental health <i>Sexual Abuse:</i> ethnicity (not Sotho), mother employed and not as labourer, step-parent present in the family
Meinck et al., (2013)	603 adolescents aged 13-19 (mean age 16.9) from a community based sample	<i>Physical and/or Emotional Abuse:</i> family conflict, unequal food distribution, inconsistent discipline, more than 3 caregiver changes, living with a biological and a step-parent, caregiver disability, food insecurity, bullying, AIDS-related stigma, sexual abuse, school non-attendance, school non-achievement Univariate Analyses: AIDS-orphaned, caregiver unwell with AIDS
Thurman, et al., 2011	1782 children aged 10-17 participating in a longitudinal intervention study for OVCs in KZN	Protective factor: living with healthy caregiver <i>Physical and/or emotional abuse:</i> Younger age (under 12), living with a chronically ill household member, parental presence, living in a semi-urban area, poor caregiver mental health, poor family functioning, caregiver formal education
Youssef, et al., 1998	2170 secondary and middle school children aged 10-20 years (mean age 14.5)	<i>Physical Abuse:</i> Child factors: younger age, higher birth, physical health problems and disability, always disobedient, disrespectful behaviour, unable to communicate with parents, repeating grades in school, smoking Parental factors: were lower education of mother (primary/preparatory), lower education of father (primary/preparatory), parental substance abuse and smoking, family arguments, insufficient income, residence shared with strangers, overcrowding Protective factors: maternal employment, father temporarily out of country for employment reasons, family support, sharing apartment with relatives, older child age

2.4.2.1 Prevalence rates of abuse

Eleven studies investigated the prevalence of child physical abuse. Rates ranged from 7.6% to 45%. However, these were greatly influenced by the measures and definitions used. Most of the studies measured lifetime occurrence of physical child abuse. Prevalence rates ranging from 15.2% to 22.5% were found by three studies which defined physical abuse as having an adult purposefully hit, punch, cut or push the child so hard that it caused bruises, scratches, bleeding, or broken bones or teeth (Madu, 2003; Madu, Idemudia, & Jegede, 2002; Madu, Idemunda, & Jegede, 2003). While the first two studies used adult retrospective self-report, the third used current adolescent self-report, which may account for the higher prevalence rate. Another study focusing on corporal punishment (defined as any hitting, smacking, burning or tying up) at home found a prevalence rate of 37.4%. Physical harm such as fractures were reported by 25.8% of respondents in this sample (Youssef, Attia, & Kamel, 1998). In another study 45% of respondents reported having experienced at least one of the following during childhood: being kicked, burned, stabbed or hit with an object (Ibrahim, Jalali, Al-Ahmadi, & Al-Bar, 2008). In

a South African survey on parental attitudes of corporal punishment, 23% of respondents reported hitting their child with an object in the last month (Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005).

Prevalence rates in samples of particularly vulnerable children also varied. Two studies investigated severe physical abuse, defined as being hit by an object likely to cause harm or hit so hard that it left marks on a monthly or more regular basis. Both studies looked at a sample of vulnerable children in areas with high HIV-prevalence in South Africa. Physical abuse prevalence rates found in these samples were 6.8% overall (Meinck, Cluver, Boyes, & Ndhlovu, 2013), 5% in healthy families, 6% in AIDS-orphaned children, 11% in children with an AIDS-ill caregiver and 12% in dually affected children (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011). These findings demonstrate high levels of severe child abuse in families affected by AIDS as compared to healthy families. Another study focusing on OVC found a 32% prevalence rate of being hit with a stick or other item in the past year; however, there was no indication about the frequency of abuse within the sample (Thurman & Kidman, 2011). A study investigating physical abuse in street girls found that 16% reported having received violent blows which left marks (Ballet, Sirven, Bhukuth, & Rousseau, 2011).

The only study in this review that used verification of reported physical abuse through physical examination found a prevalence rate of 7.6%. Physical abuse was defined as being beaten to the point of bruising, wounding, fracturing or worse (Afifi, El-Lawindi, Ahmed, & Basily, 2003). While this study only measured children who experienced ongoing physical abuse, these findings appear the most solid due to medical confirmation of abuse. However, the physicians would not have been able to identify physical abuse that did not leave marks in cases where marks had healed.

Seven studies investigated the prevalence of child emotional abuse. Rates ranged from 11.9% to 50.6%. However, these were greatly influenced by the measures and definitions of emotional

abuse used and the populations sampled. Only two studies reported the frequency of the experienced abuse (Cluver et al., 2011; Meinck et al., 2013). While the authors of one study developed their own measure of emotional abuse (Afifi et al., 2003), the remaining six studies used scales already available (Cluver et al., 2011; Ibrahim et al., 2008; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Meinck et al., 2013).

Fourteen studies investigated the prevalence of child sexual abuse. Rates ranged from 1.6% to 77.7%. However, these were greatly influenced by the measures and definitions used and populations sampled. All of the studies measured lifetime occurrence of sexual child abuse. Prevalence rates for any type of contact sexual abuse (kissing, fondling, forced sex) ranged from 25.6% to 54.2% (Madu, 2003; Madu & Peltzer, 2000). Four studies researched unwanted touching of genitals and found prevalence rates ranging from 7% to 33% (Afifi et al., 2003; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). Three studies investigated unwanted penetration (objects or body parts placed in the vagina or anus) and found prevalence rates ranging from 8.7% to 15.7% (Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). One study investigated forced sex and found a prevalence rate of 5.8% (King et al., 2004). Studies focusing exclusively on sexual abuse of boys found 44% of high school students have had forced sex and 28.9% of university students have experienced contact sexual abuse including forced sex in childhood (Anderson & Ho-Foster, 2008; Collings, 1991). Two studies investigated forced sex during childhood in females and found prevalence rates of 1.6% and 2.9%. One used a nationally representative sample of South African women and the other used a sample of university students in Egypt (Ibrahim et al., 2008; Jewkes, Levin, Mbananga, & Bradshaw, 2002). One study investigated lifetime contact sexual abuse in female children in Swaziland and found a prevalence rate of 33% (Breiding et al., 2011; Reza et al., 2009).

Studies of very vulnerable children found prevalence rates of 77.7% for forced sex amongst street girls in Nigeria (Audu, Geidam, & Jarma, 2009), 33.9% for contact sexual abuse amongst patients in a psychiatric treatment centre (Berard & Boormeester, 1999), 53% for contact sexual abuse and 48% for forced sex amongst attendees of a youth stress clinic (Carey, Walker, Roussow, Seedat, & Stein, 2008).

Prevalence rates for multiple abuse victimisation were measured by two studies and ranged from 9.7% to 25.8% amongst respondents who reported at least two types of abuse (physical, emotional or sexual) (Afifi et al., 2003; Ibrahim et al., 2008). Both studies were carried out in Egypt, one using a sample of high school students, the other, female university students.

2.4.2.2 Correlates of physical child abuse (Table 2-3)

Twelve studies investigated correlates of child physical abuse victimisation on the African continent. Where available, odds ratios or p-values will be stated in parentheses following the individual correlates.

2.4.2.2.1 Child physical abuse: Community-level correlates

Out of the twelve studies that focused on correlates of physical abuse, one study found living in a semi-urban environment compared to urban areas (OR 2.46) (Thurman & Kidman, 2011) to be associated with child physical abuse victimisation.

2.4.2.2.2 Child physical abuse: Household-level correlates

Two studies found poverty-related factors to be associated with physical abuse victimisation. Going to bed hungry (OR 2.40) (Meinck et al., 2013), overcrowding (OR 1.14), sharing the house with strangers (OR 1.69) and not having enough income (OR 2.59) all increased the risk for physical child abuse (Youssef et al., 1998). One study found that family units with four to five members ($p < 0.01$) (Collings, 1993) and another found that unequal food distribution (OR 2.96) (Meinck et al., 2013) were both also associated with physical abuse victimisation.

2.4.2.2.3 Child physical abuse: Caregiver-level correlates

Five studies found domestic violence or family conflict to be correlates of physical child abuse victimisation (OR 2.11 - 2.66) (Ibrahim et al., 2008; Madu, 2003; Madu et al., 2003; Meinck et al., 2013; Youssef et al., 1998). Four studies found illness within the household to be a risk for physical abuse victimisation. Caregiver AIDS-illness (OR 2.25), being dually affected by AIDS (OR 3.35) (Cluver et al., 2011), living in a household with an ill adult (OR 1.32) (Thurman & Kidman, 2011), caregiver disability (OR 1.10), and experience of AIDS-related stigma (OR 1.61) (Meinck et al., 2013) all put children at increased risk of physical abuse. Two studies found that poor caregiver mental health was associated with physical abuse (OR 1.20 and 2.59) (Madu et al., 2003; Thurman & Kidman, 2011). In addition, caregiver drug and alcohol abuse were identified as correlates by two studies (OR 2.26 and 1.45) (Madu et al., 2002; Youssef et al., 1998). One study found that more than three caregiver changes (OR 2.38) increased the risk for physical abuse victimisation (Meinck et al., 2013), and another found the same for poor family functioning (OR 1.49) (Thurman & Kidman, 2011). Factors associated with physical abuse victimisation in a single study were maternal disinterest (OR 36.9) (Afifi, et al., 2003), inconsistent discipline (OR 2.01) (Meinck et al., 2013), female single parents, single and previously married parents, and attitudes to corporal punishment and empathic parenting (Dawes et al., 2005).

2.4.2.2.4 Child physical abuse: Child-level correlates

Four studies found that younger child age (OR 3.02) (Collings, 1993; Dawes et al., 2005; Thurman & Kidman, 2011; Youssef et al., 1998) was associated with physical abuse victimisation. One study identified child disabilities, birth defects, and chronic health problems as being associated with an increased risk of physical abuse victimisation (OR 2.59) (Youssef et al., 1998). Two studies also found that school non-achievement was associated with physical abuse victimisation (OR 1.82 and 1.91) (Meinck et al., 2013; Youssef et al., 1998). Child factors associated with physical abuse victimisation in single studies were injury signs (OR 688.3)

(Afifi et al., 2003), male gender ($p<0.01$), white race ($p<0.05$) (Collings, 1993), school non-attendance (OR 2.76), sexual abuse victimisation (OR 3.28), bullying (OR 2.74) (Meinck et al., 2013), disrespectful behaviour towards parents (OR 2.14), being disobedient (OR 2.06), inability to communicate with parents (OR 2.76) and smoking (1.62) (Youssef et al., 1998).

2.4.2.3 Child physical abuse: Conflicting results

Having a younger mother ($p<0.01$) and an older father ($p<0.05$) was found to be associated with physical abuse in one study (Collings, 1993), while older parental age was found to be a correlate in another study (Dawes, et al., 2005). It is also unclear whether parental education or living with a step-parent are correlates of physical abuse. Two studies found that maternal education below university level increased the risk for physical abuse (OR 1.26 and 3.03) (Ibrahim et al., 2008; Youssef et al., 1998). One study found that having caregivers with any formal education increased the risk for physical abuse victimisation (OR 1.4) (Thurman & Kidman, 2011). One study found that mothers with higher education were more likely to abuse their children (OR 22.3) (Afifi et al., 2003), while another found paternal education below university level was associated with physical child abuse (OR 2.99) (Youssef et al., 1998). One study found that living with a biological parent and step-parent (OR 4.36) is a correlate (Meinck et al., 2013), whereas another found that children living with biological caregivers (OR 1.77) were more at risk for physical abuse (Thurman & Kidman, 2011).

One study carried out with female street children found highly conflicting results for factors associated with physical and emotional abuse victimisation. Correlates of higher rates of physical and emotional abuse were parents living together, father present in the household, father's employment, mother's employment and living in the city of Nouadhibou (all significant at $p<0.005$). Factors found to be protective of physical abuse victimisation in this study were highly unusual, including parents divorced or deceased, father's absence, father employed as a soldier, mother unemployed or working as a prostitute, and living in the capital city of

Nouakchott instead of Nouadhibou (all significant at $p < 0.005$) (Ballet et al., 2011). These factors might be proxies rather than protective factors. For example, an unemployed mother may be more likely to be at home to protect children from abuse in cases where the father is the perpetrator. A mother working as a prostitute may suggest financial autonomy and lower her likelihood of staying in a relationship with an abusive partner. This study compared risks of physical abuse of street girls in two cities in Mauritania through multiple correspondence analyses, an approach generally used to determine underlying structures within the data rather than model risk factors. It is also unlikely that any of these protective factors can be used for future intervention design.

Potential protective factors were also found in one study. Maternal employment (OR 0.68), father temporarily out of the country for employment reasons (OR 0.27), family support (OR 0.5), sharing housing with relatives (OR 0.66) and older child age (OR 0.75) were found to decrease the risk of physical child abuse victimisation (Youssef et al., 1998).

2.4.2.4 Child physical abuse: Critical appraisal of studies

The studies reviewed were very heterogeneous which makes comparison difficult. Out of the twelve studies that reported correlates of physical abuse, eight did not report the frequency of the experienced abuse (Afifi et al., 2003; Ballet et al., 2011; Collings, 1993; Ibrahim et al., 2008; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Thurman & Kidman, 2011). Four studies did not give confidence intervals for their odds ratios (Madu, 2003; Madu et al., 2002; Madu et al., 2003; Thurman & Kidman, 2011), and one study had confidence intervals so large that a clear statement regarding the results cannot be made (Afifi et al., 2003). Two studies did not carry out regression analysis but instead used chi-square tests which did not allow them to control for socio-demographic co-variables (Collings, 1993; Dawes et al., 2005). One study used factor analysis to investigate relationships between potential correlates by comparing two cities (Ballet et al., 2011). *P*-values were also not reported in one of the studies, and it is therefore

unclear whether the findings were statistically significant. However, this is the only study in this review examining parental patterns of corporal punishment using parental self-report, and its findings could be of value for future intervention design (Dawes et al., 2005). The majority of studies did not discuss the potential for reverse directionality, confounding variables and possible pathways of the relationships.

Two studies measured multiple abuse victimisation for physical and emotional abuse together, but did not separate by abuse type. It is therefore unclear whether a certain type of abuse was the actual driver of the significance found for correlated factors. In addition, interviewer-guided questionnaires were used, and under-reporting might be higher than in self-guided questionnaires. Because these studies used current adolescent-self report, however, they are less likely to be subject to recall bias (Meinck et al., 2013; Thurman & Kidman, 2011).

Six studies were classroom-based, but it was unclear in four of them how confidentiality was granted within the classroom setting (Afifi et al., 2003; Ibrahim et al., 2008; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Youssef et al., 1998). In one study, it was unclear whether data were collected in the classroom or whether students were allowed to take the questionnaires home with them (Ibrahim et al., 2008). While all of these studies give valuable indications about the severity of child abuse in populations of school and university students, future research could valuably investigate whether these findings would be similar in a community-based sample that includes children who do not attend school or university.

Four of the studies did not clearly describe the development of the questionnaire items or the construction of some of the variables (Afifi et al., 2003; Ballet et al., 2011; Thurman & Kidman, 2011; Youssef et al., 1998). Two studies lacked description of the theoretical framework or research hypothesis. Multivariate models were presented but reasons for inclusion and exclusion of variables and covariates were not given (Afifi et al., 2003; Ibrahim et al., 2008). Two of the studies lacked an indication of whether ethical approval was granted or not (Ibrahim

et al., 2008; Madu, 2003). One study only sampled orphans and other vulnerable children (OVC) who were part of an intervention for OVC and their families (Thurman & Kidman, 2011). Two studies used a community-based sample and oversampled orphans and child-headed households since the main aim was to investigate the impact of familial AIDS on children (Cluver et al., 2011; Meinck et al., 2013). Two of these studies combined physical and emotional abuse for their correlate analysis, so it is unclear which relationship might be driving the association (Meinck et al., 2013; Thurman & Kidman, 2011). While these are the first studies investigating abuse in orphans, vulnerable children and children affected by AIDS, thereby making important contributions to the evidence for this population group, future research could valuably identify whether these results hold in community-based samples. As these studies found high prevalence rates of abuse in OVC, it will be important to identify whether OVC are at higher risk of abuse compared to groups of non-OVC. One study examined physical abuse in female street children sampled through NGOs (Ballet et al., 2011). While this study investigated the risk for physical abuse victimisation in another group of highly vulnerable children, making an important contribution to the literature, it would be of great value to include street children who are not accessing services in future studies.

2.4.2.5 Correlates of emotional child abuse (Table 2-3)

2.4.2.5.1 Child emotional abuse: Household-level correlates

Out of six studies investigating correlates of child emotional abuse victimisation, three found domestic violence to be associated (OR 2.15 to 4.30) (Ibrahim et al., 2008; Madu et al., 2002; Madu et al., 2003). One study found overcrowding to be correlated (OR 1.7) (Afifi et al., 2003).

2.4.2.5.2 Child emotional abuse: Caregiver-level correlates

Out of six studies investigating correlates of child emotional abuse victimisation, one found having a caregiver ill with AIDS (OR 2.26), being AIDS-orphaned (OR 2.22) and being dually affected by AIDS (OR 3.93) to be correlates of emotional child abuse. In addition, living with

a step-parent or adoptive father was also associated with emotional abuse victimisation in one study (OR 2.30).

2.4.2.5.3 Child emotional abuse: Child-level correlates

Only one study found child-level correlates of emotional abuse victimisation and identified child illness (OR 4.7) as the only factor (Afifi et al., 2003).

2.4.2.5.4 Child emotional abuse: Conflicting results

Caregiver mental health problems were found to be correlated with emotional child abuse victimisation in two studies (OR 1.53 and 2.70) (Ibrahim et al., 2008; Madu et al., 2002), while one very similar study did not find an association (Madu et al., 2003).

2.4.2.6 Child emotional abuse: Critical appraisal of studies

Out of six studies investigating correlates of emotional child abuse victimisation, five did not report the frequency of abuse (Afifi et al., 2003; Ibrahim et al., 2008; Madu, 2003; Madu et al., 2002; Madu et al., 2003). Three did not report confidence intervals for their odds ratio (Madu, 2003; Madu et al., 2002; Madu et al., 2003) while one had very large confidence intervals (Afifi et al., 2003), suggesting imprecision or measurement errors. Four studies were classroom-based, but it was unclear in all of them how confidentiality was guaranteed (Afifi et al., 2003; Madu, 2003; Madu et al., 2002; Madu et al., 2003). All studies were cross-sectional, and therefore directionality of the association could not be established. Only one study used a community-based sample of vulnerable children (Cluver et al., 2011). Five studies used samples of high school and university students. Even though results from these studies cannot be generalised, they give valuable information about correlates in these particular populations. Two of the studies lacked a description of whether ethical approval was granted (Ibrahim et al., 2008; Madu, 2003), and two studies did not describe a theoretical framework or research question (Afifi et al., 2003; Ibrahim et al., 2008). In addition, one of the studies provided no information regarding the development of their emotional abuse measure (Afifi et al., 2003).

2.4.2.7 Correlates of sexual child abuse (Table 2-3)

2.4.2.7.1 Child sexual abuse: Community-level correlates

Out of 16 studies investigating correlates of sexual abuse victimisation, one study found living in less developed provinces and rural areas (OR 1.7) to be correlated (Anderson & Ho-Foster, 2008), whereas another study found that living in the Western Cape (one of the most developed provinces in South Africa) increased the risk for sexual abuse victimisation ($p < 0.001$) (Jewkes et al., 2002). However, the first study examined school boy sexual victimisation while the second investigated childhood rape in a nationally representative sample of women. Therefore, the findings of the two studies might not be comparable.

2.4.2.7.2 Child sexual abuse: Household-level correlates

Three out of 17 studies found that emotional abuse (OR 2.06) and verbal insults ($p < 0.001$) were associated with sexual abuse victimisation (Anderson & Ho-Foster, 2008; Breiding et al., 2011; Carey et al., 2008). Another two found physical abuse correlated with experience of sexual abuse (OR 4.17 and $p = 0.013$) (Anderson & Ho-Foster, 2008; Carey et al., 2008). Two studies found large family units ($p < 0.01$) and a greater number of people in the household to be associated with sexual abuse (OR 1.04) (Breiding et al., 2011; Collings, 1993). Other household-level factors associated with sexual abuse victimisation were living in a non-nuclear family ($p < 0.001$) (Berard & Boermeester, 1999), and receiving a disability grant (OR 6.69) (Carey et al., 2008).

2.4.2.7.3 Child sexual abuse: Caregiver-level correlates

Four studies found caregiver status such as living with a single parent (OR 1.74) (Carey et al., 2008; Collings, 1991; King et al., 2004) and parents not living together (OR 1.58 and 1.82) (Carey et al., 2008; Ibrahim et al., 2008) correlated with sexual abuse victimisation. Three studies found domestic violence to be associated with child sexual abuse victimisation (OR 2.04 and 2.02 and $p < 0.05$) (Ibrahim et al., 2008; Madu et al., 2002; Madu & Peltzer, 2000).

Living with a step-parent during childhood was a correlate of child sexual abuse (OR 2.59 and 2.01 and $p < .05$) in three studies (King et al., 2004; Madu, 2003; Madu & Peltzer, 2000). Three other studies investigated the relationship between child and mother, and they found maternal disinterest (OR 48.6), parental rejection and not having a close relationship with one's mother (OR 1.88) to be correlates (Afifi et al., 2003; Breiding et al., 2011; Collings, 1991). Three studies found parental drug or alcohol addiction to be associated with child sexual abuse (OR 2.11 to 2.4) (Berard & Boermeester, 1999; Ibrahim et al., 2008; Madu et al., 2003). Parental mental health problems were found to be correlated with sexual abuse victimisation in childhood by two studies (OR 2.69 and 3.02) (Madu et al., 2002; Madu et al., 2003). Other caregiver-level factors associated with sexual abuse victimisation were mother's education below university-level (OR 1.57) (Ibrahim et al., 2008), older father ($p < 0.05$), older mother ($p < 0.01$) (Collings, 1993), mother employed above the level of labourer ($p < 0.05$) (Madu & Peltzer, 2000) and parental punitiveness (Collings, 1991).

2.4.2.7.4 Child sexual abuse: Child-level correlates

Three studies found females to be at higher risk for child sexual abuse (OR 1.85 and $p < 0.01$, and OR 3.85) (Carey et al., 2008; Collings, 1993; King et al., 2004). The majority of females reporting rape were part of an older age group in several studies whereas a conflicting study found that younger girls were at greater risk (OR 3.54) (Audu et al., 2009). A second study interviewed women about their childhood rape experiences up to age 15 and younger women were more likely to report rape (OR .074), possibly because the incident was more recent (Jewkes et al., 2002). One study found orphanhood to be a significant correlate of sexual abuse victimisation. For female abuse victims, double orphanhood (OR 1.8), maternal orphanhood (OR 3.9) and paternal orphanhood (OR 1.3) were found to be associated with sexual abuse victimisation (Birdthistle et al., 2011). However, another study did not find significant association between orphanhood and reported sexual child abuse (Cluver et al., 2011).

Ethnicity was also found to be associated with sexual child abuse. One study found children of Coloured³ background to be at higher risk of abuse ($p < 0.05$) (Collings, 1993). Another found white females to be at highest risk (OR 2.57) (Jewkes et al., 2002). One found being Black to be a correlate (Collings, 1991). Yet another found ethnicities other than Northern Sotho⁴, i.e., White, Coloured or other ($p < 0.05$), to be associated with sexual victimisation (Madu et al., 2002). However, this association might be due to sampling bias: more than 50% of the children in one study were coloured whereas less than a quarter of children in the other study were not Northern Sotho. In addition, two of these studies were carried out in South Africa during the years of Apartheid when Black youth were less likely to access tertiary education.

Child factors also found to be associated with sexual victimisation were child hyperactivity (OR 11.8), child disability (OR 9.1), and wasting⁵ (OR 481.8) (Afifi et al., 2003). Externalising and internalising child factors associated with abuse victimisation were anti-social behaviour (OR 1.44), alcohol consumption (OR 2.00) and suicide attempts (OR 3.22) (King et al., 2004). However, directionality cannot be assumed as all of these studies were cross-sectional, e.g., children might show anti-social behaviour as a result of sexual abuse rather than anti-social behaviour leading to sexual abuse victimisation. One study found that children's knowledge of peers who were assaulted (OR 1.59) and knowledge of someone having sex with a teacher (OR 1.68) were associated with sexual abuse victimisation (Breiding et al., 2011). Other child factors were: not attending school (OR 2.12) (Birdthistle et al., 2011), working more than two jobs (OR 16.09), working more than 8 hours (OR 4.43) and having no formal education (OR 4.79) (Audu et al., 2009).

³ Under Apartheid, this term referred to a group of people of mixed race who had native African or Asian and European ethnic ancestries. Coloured people had higher social and economic status under Apartheid than Blacks and were mainly used as skilled workers by the white South African population. (<http://www.britannica.com/EBchecked/topic/126829/Coloured>, 22/01/2011).

⁴ Northern Sotho is a Nguni Language spoken by the Basotho people in South Africa. It is one of 11 official languages. In this study, Tsonga and Venda (two other official languages) speakers were also included in the group of Northern Sotho speakers.

⁵ Wasting syndrome is defined as ongoing involuntary weight loss, particularly of muscle mass, due to chronic illnesses such as AIDS, cancer or diabetes. <http://medical-dictionary.thefreedictionary.com/cachexia>

Three studies found factors protective against sexual abuse victimisation. These were high birth order of child (OR 0.6) (Afifi et al., 2003), father's employment as a trader (OR 0.05), father's employment as a senior civil servant (OR 0.14), mother's employment as a senior civil servant (OR 0.26) (Audu et al., 2009), living with at least one biological parent (OR .016) (Collings, 2005) and living with the biological mother before turning 16 (OR .039) (Madu, 2003).

2.4.2.7.5 Child sexual abuse: Critical appraisal of studies

Of the 17 studies focusing on correlates of sexual child abuse, three investigated victimisation in boys alone (Anderson & Ho-Foster, 2008; Collings, 1991, 2005). Four of the studies investigated victimisation only in girls (Audu et al., 2009; Breiding et al., 2011; Ibrahim et al., 2008; Jewkes et al., 2002). Eight investigated victimisation for both genders. Three studies investigated particularly vulnerable groups such as children hawking on the street or children attending out-patient mental health units (Audu et al., 2009; Berard & Boermeester, 1999; Carey et al., 2008). Nine studies were carried out in schools or universities (Afifi et al., 2003; Anderson & Ho-Foster, 2008; Collings, 1991; Ibrahim et al., 2008; King et al., 2004; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). Two studies used a community-based sample (Audu et al., 2009; Breiding et al., 2011), one used a nationally representative sample (Jewkes et al., 2002), one surveyed mental health patients (Carey et al., 2008) and four reviewed case files alone (Berard & Boermeester, 1999; Birdthistle et al., 2011; Collings, 1993, 2005).

Thirteen studies did not report a theoretical framework used as a basis for hypothesis generation (Afifi et al., 2003; Anderson & Ho-Foster, 2008; Audu et al., 2009; Berard & Boermeester, 1999; Birdthistle et al., 2011; Carey et al., 2008; Collings, 1991; Ibrahim et al., 2008; Jewkes et al., 2002; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). Six studies did not report whether they had obtained ethical approval (Afifi et al., 2003; Berard & Boermeester, 1999; Carey et al., 2008; Collings, 1991; Ibrahim et al., 2008; Madu, 2003; Madu

et al., 2003). Ten studies did not discuss reverse directionality of the association, or the fact that directionality cannot be assumed in cross-sectional studies (although many were careful not to insinuate causality) (Afifi et al., 2003; Audu et al., 2009; Berard & Boormeester, 1999; Breiding et al., 2011; Collings, 1991; Ibrahim et al., 2008; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). 14 studies did not report the frequency and time period of abuse (Afifi et al., 2003; Anderson & Ho-Foster, 2008; Audu et al., 2009; Birdthistle et al., 2011; Breiding et al., 2011; Carey et al., 2008; Collings, 1991; Ibrahim et al., 2008; Jewkes et al., 2002; King et al., 2004; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000). Seven studies administered the questionnaire within the classroom environment (Afifi et al., 2003; Anderson & Ho-Foster, 2008; King et al., 2004; Madu, 2003; Madu et al., 2002; Madu et al., 2003; Madu & Peltzer, 2000), but only two studies discussed issues of confidentiality within a classroom setting (Anderson & Ho-Foster, 2008; Collings, 1991). In one study, it was unclear whether data were collected in the classroom or whether participants were allowed to take the questionnaire home (Ibrahim et al., 2008). Only four studies which interviewed minors discussed referral processes for children asking for help or at risk of significant harm (Breiding et al., 2011; Carey et al., 2008; Madu et al., 2002; Madu & Peltzer, 2000)

Out of 17 studies investigating child sexual abuse victimisation, six used current child self-report (Afifi et al., 2003; Anderson & Ho-Foster, 2008; Audu et al., 2009; Carey et al., 2008; King et al., 2004; Madu & Peltzer, 2000), three used retrospective adult self-report (Collings, 1991; Ibrahim et al., 2008; Jewkes et al., 2002) and four had samples which used both (Breiding et al., 2011; Madu, 2003; Madu et al., 2002; Madu et al., 2003). Four studies reviewed charts of children and adolescents attending sexual abuse clinics (Berard & Boormeester, 1999; Birdthistle et al., 2011) or using social work services (Collings, 1993, 2005). Whilst these studies are limited because they do not contain a non-abused comparison group, they provide useful indications for correlates of abuse in cases where health and social services were notified.

Three studies investigated sub-groups of especially vulnerable children, such as street hawkers and those with mental health problems (Audu et al., 2009; Berard & Boermeester, 1999; Carey et al., 2008). Whilst these findings cannot be generalised, they provide valuable indications for a group of children at particularly high risk for sexual abuse victimisation. Children who experience abuse are more likely to suffer from mental health problems and are therefore more likely to access psychiatric care. In addition, the abuse could have been the traumatic event which caused the child to seek help. In some instances, this was clearly the case. It is important to consider these studies as they focus on a particularly high-risk group.

Three studies -two involving chart reviews and one using a sample of university psychology students- were carried out in South Africa before the end of Apartheid. These therefore used biased samples (Berard & Boermeester, 1999; Collings, 1991, 1993) as black citizens had much less access to social and psycho-social services or university education than other population groups.

2.4.2.8 Multiple abuse victimisation

Out of the 23 studies included in this review, two also investigated multiple abuse victimisation in children (Afifi et al., 2003; Ibrahim et al., 2008). Both studies investigated household-level factors and found domestic violence or family problems to be associated with multiple abuse victimisation (OR 2.54 and 53.7 respectively). Caregiver-level factors were also investigated in both studies. Both studies found parental illness or mental health problems to be factors associated with multiple abuse victimisation (OR 1.77 and 71.6). Caregiver-level factors identified in a single study were parents who quarrel with their child (OR 18), maternal cruelty (OR 135.8) (Afifi et al., 2003), mother's education lower than university-level (OR 1.83) and parents not living together (OR 1.62) (Ibrahim et al., 2008). Protective factors were found to be high birth order of child and parental predominance (Afifi et al., 2003).

2.5 Discussion

Empirical research on correlates and protective factors for child abuse on the African continent remains limited, although sexual abuse has been investigated more extensively than physical abuse. Hardly any evidence is available for emotional abuse. Available studies are severely heterogeneous in terms of sample, recruitment, scales used and definitions of physical, emotional and sexual child abuse (Table 2). This heterogeneity and the diverse contexts in which these studies are nested make cross-comparisons difficult.

Despite these differences in cultures, samples and countries, however, some patterns seem to emerge. Prevalence rates across all studies and abuse types are consistently high despite heterogeneous measuring tools, differing definitions of child abuse and differences in the populations sampled. The sample populations varied from primary school students and high school students to university-level psychology students and community members.

Prevalence rates of physical abuse within these studies varied between 7.6% and 45% depending on definitions and measures used. In general, studies from Egypt found considerably higher prevalence rates of physical abuse than studies from South Africa. This may be due to greater acceptability of corporal punishment, stricter discipline and more traditional family settings with clear hierarchical structures in Egypt. However, these observations remain speculative as there is no supporting research evidence. Corporal punishment appears to be less acceptable in South Africa as the country abolished all corporal punishment in schools in 1996. In Egypt, where corporal punishment in school is legal, a study showed that between 60% and 80% of school children had experienced it in their lifetime (Pinheiro, 2006). One study compared particularly vulnerable children to other children and found that those affected by AIDS and those orphaned by AIDS were at greater risk of severe abuse (Cluver et al., 2011). Studies used various definitions of physical abuse, and few reported the severity and frequency of the abuse. As a result, many studies categorised children who had been hit once with children who experienced regular and severe physical abuse.

Prevalence rates of emotional abuse within these studies varied between 11.9% and 50.6% depending on definitions and measures used. In general, emotional abuse appears to be widely practiced across the continent. This may be due to adverse conditions in infancy, such as extreme poverty or maternal depression, which may have negatively impacted the early mother-child relationship or affected attachment (Martins & Gaffan, 2000), which is correlated with abuse (Van Ijzendoorn & Bakermans-Kranenburg, 1999). This may be a particular concern in areas such as South Africa where rates of extreme poverty and post-partum depression are high and have shown to lead to severely insensitive engagement with the infant (Cooper et al., 1999).

Prevalence rates of sexual abuse between the studies varied from 1.6% to 77.7% depending on the definition and measures used. In general, studies from South Africa found higher prevalence rates for all variations of sexual abuse compared to studies from Egypt. This corresponds with higher rates of reported sexual violence within South Africa, where 62,514 sexual assault cases are reported to the police annually (European Institute for Crime Prevention and Control, 2010; South African Police Service, 2012). Egypt is reported to have one of the lowest sexual assault prevalence rates in the world (UNODC, 2008). However, numbers of reported sexual abuse cases generally do not reflect the actual prevalence and incidence of sexual abuse. Anecdotal and qualitative evidence from both Egypt and South Africa suggest that under-reporting is rife and post-abuse services often re-victimize survivors and children, making their families hesitant to report sexual abuse victimisation (Abdelhadi, 2008; Roehrs, 2011). Studies using current child self-report tended to report higher prevalence rates for child sexual abuse compared to studies using adult retrospective self-report, which might suggest recall bias. In addition, the age range of adults interviewed varied from 18-24 to 15-49, with one study reporting that older women were less likely to report child rape experience (Jewkes et al., 2002). Studies investigating sexual abuse in particularly vulnerable children found very high rates of reported child sexual abuse, as one might expect. Girls on the street seem to be at particularly high risk of sexual abuse. Children recruited from psychiatric clinics might be subjected to sampling bias

as it is possible that they sought psychiatric support in order to deal with trauma from sexual abuse victimisation.

For some studies, particularly sexual abuse studies, prevalence rates were lower in African samples compared to those observed in high income countries. However, there is a dearth of research. Where studies exist, these show many methodological problems, particularly with regards to questionnaire design and a failure on the part of the authors to describe the questionnaire development process. School-based studies also offer a potential lack of confidentiality. These methodological problems are likely to have led to inconsistencies in reporting of abuse. In addition, disclosure and discussion of issues such as child abuse victimisation may be culturally affected. In societies where sexuality or sexual matters are taboo (not discussed) and no sex education is available, disclosure may be more difficult for victims (Fontes & Plummer, 2010). In particular, evidence suggests that where loss of virginity may mean being unable to marry or dishonouring the family, victims may be more hesitant to disclose sexual abuse (Baker & Dwairy, 2003). Further methodologically rigorous research is crucial to establish how culture affects reporting behaviour.

In addition, studies which found lower prevalence rates of child physical abuse on the African continent used very strict definitions. In one study a physician needed to confirm the physical abuse through examination (Afifi et al., 2003). In two other studies, only children who experienced ongoing abuse monthly or more frequently were categorised as abuse victims (Cluver et al., 2011; Meinck et al., 2013).

Findings demonstrate correlates of abuse on all levels of the Ecological Framework (Belsky, 1993; Bronfenbrenner, 1979). For physical child abuse, some caregiver-level factors appear to be more influential on risk of victimisation than others. Domestic violence was the factor most commonly associated with physical child abuse (5 studies). This finding corresponds with evidence from high income countries where a considerable co-occurrence between child abuse

and a child's exposure to domestic violence appears to exist. This co-occurrence of domestic violence and child abuse might have a compounding effect on children with even higher risk for negative outcomes (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). Physical illness of the caregiver appeared to be another influential correlate within the caregiver-level (4 studies). In particular, children living with someone ill with AIDS or chronic illnesses or with a physical disability appeared to be at higher risk for physical abuse victimisation. This may be caused by increased family stress. Unemployment and high levels of AIDS-related stigma may also impact on caregiver mental health. Stigma and poor mental health have been found to be major correlates of child abuse victimisation within this review. AIDS-related stigma is common in many countries and might be inflicted by the community or within the family through gossip or maltreating or disowning affected family members (Campbell et al., 2005).

Mothers suffering from chronic pain report poorer mother-child relationships and more inconsistent parenting, which in itself is a correlate of child abuse victimisation (Black, Heyman, & Smith Slep, 2001a; Evans, Shipton, & Keenan, 2006; Stith et al., 2009). As mentioned above, caregiver mental health was also associated with physical abuse victimisation. This corresponds with findings from reviews from high income countries which identify strong links between parental mental health problems and child abuse (Black et al., 2001a). Correspondingly, there are strong links between poor maternal mental health and domestic violence (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008). In addition, households where caregivers suffer from chronic illnesses are at higher risk for income deprivation, particularly if they come from communities with a high disease burden and restricted access to health care (Bradshaw & Steyn, 2001).

At the household-level, poverty was found to be associated with physical child abuse victimisation (2 studies). This corresponds to evidence from high income countries where poverty often co-occurs with an increased risk for physical abuse victimisation (Gillham et al.,

1998). The underlying causes for this phenomenon (e.g., increased family stress or higher likelihood of living in a violent area) are not entirely understood (Drake & Pandey, 1996). Depending on the underlying causes, an increase in family income may decrease the risk for physical child abuse victimisation; however, further research is needed to address this question (Berger, 2004; Cancian, Shook Slak, & Yang, 2010).

At the child-level, younger age was found to be associated with physical child abuse victimisation in Africa (4 studies). This was also found to be the case in high income countries where younger and smaller children as well as those in early stages of development appear to be more at risk (World Health Organization, 2002). Young children are also at higher risk for very severe outcomes, such as fatal injuries following physical child abuse (Keenan et al., 2003). Another child-factor associated with physical abuse victimisation was school non-achievement (2 studies). However, it is unclear whether children who are physically abused attend school less or whether skipping school results in physical abuse in the home. In addition, not attending school may be part of an abuse pattern rather than the child's choice. School non-attendance and poor performance were also found to be associated with physical abuse in high income countries (Kurtz, Gaudin Jr, Wodarski, & Howing, 1993).

Conflicting results were found regarding the following caregiver-level factors: age, education, and biological versus non-biological caregiver. Findings from reviews in high income countries are also unclear. Some find no relationship between older caregiver age and physical abuse victimisation (Stith et al., 2009), while others find a higher risk for physical child abuse in younger parents (Black et al., 2001a). Conflicting results have also been found regarding level of parental education in high income countries. More research is needed to understand how caregiver education is associated with physical child abuse and which factors might influence this relationship (Black et al., 2001a). Living with a non-biological caregiver was not associated with physical abuse victimisation in a review of studies from high income countries (Stith et

al., 2009). However, not many studies have investigated this factor in high- or low- and middle-income countries.

Other factors associated with physical abuse on all levels of the Ecological Framework were also identified by this review (see results section). However, these findings were limited to single studies and need to be investigated further.

Correlates of emotional abuse have been insufficiently investigated in Africa thus far. Those studies which hypothesised similar correlates found conflicting results. The majority of studies investigated different correlates of emotional abuse. Only domestic violence was found to be associated with emotional abuse victimisation across different studies and countries (3 studies).

Correlates of child sexual abuse were particularly dominant on the caregiver-level of the Ecological Framework. Relationship status of the caregiver (i.e., single parent or divorced parents) was found to be associated with sexual abuse victimisation (4 studies). This was also found by evidence from high income countries (Black, Heyman, & Smith Slep, 2001b; Finkelhor, Hotaling, Lewis, & Smith, 1990). It is unclear whether children in single-parent families are more vulnerable because they are less supervised, have poorer relationships with their caregivers, or have step-parents involved with caretaking responsibilities. Living with a step-parent was also found to be a correlate of sexual abuse victimisation although it is unclear whether the step-parent was the perpetrator (3 studies). There is also some evidence from high income countries which suggests that living with a non-biological parent increases the risk for sexual abuse victimisation, although the pathways are yet unclear (Black et al., 2001b).

Domestic violence was also found to be a common correlate of child sexual abuse victimisation (3 studies). Evidence from the United States showed that domestic violence in the household increased the risk for incestuous sexual abuse five-fold (Stroebe et al., 2013). However, studies in the African context measured all types of sexual abuse experience, not only incestuous incidents. Children who witness domestic violence seem to be at higher risk of engaging in

risky sexual behaviours and might therefore be at higher risk for sexual abuse victimisation (Elliott, Avery, Fishman, & Hoshiko, 2002).

Poor parent-child relationship was also found to be a correlate of sexual abuse victimisation (3 studies). In particular, poor mother-daughter relationships increased the risk for sexual child abuse. This corresponds to evidence from high income countries which describes exactly the same phenomenon (Black et al., 2001b). Parental drug and alcohol use were also found to be associated with sexual child abuse (3 studies). This was found also in studies from high income countries; however, different types of substances may predict different types of child abuse (Famularo, Kinscherff, & Fenton, 1992; Walsh, MacMillan, & Jamieson, 2003). Thus far, it is unclear what the mechanisms between parental substance abuse and sexual child abuse victimisation are.

Parental mental health was also found to be a caregiver-level correlate (2 studies). This was also reported from high income countries. It is, however, generally unclear whether poor mental health precedes or succeeds child sexual abuse (Black et al., 2001b). Some evidence from prospective longitudinal studies suggests that mothers of sexually-abused children report being more stressed and anxious than mothers of non-abused children (Pianta, Egeland, & Erikson, 1989).

Factors for sexual abuse victimisation were also identified on the child-level. Being female (3 studies) was a correlate of being sexually victimised. Many of the studies included in this review used male- or female-only samples, and therefore it is impossible to be conclusive. However, when male and female samples were compared, females were at much higher risk for sexual abuse victimisation, rape in particular. This corresponds to global evidence on sexual child abuse victimisation (Pereda, Guilera, Forns, & Gómez-Benito, 2009). Gender may also play a role in the disclosure and reporting of sexual abuse, however, with boys fearing higher levels of stigma following victimisation disclosure (Spaventa, 2007).

Factors for sexual abuse victimisation were also identified at the household-level. Emotional abuse (3 studies) and physical abuse (2 studies) were identified as correlates. It is unclear whether emotional and physical abuse victimisation preceded sexual abuse, making children more vulnerable, or whether emotional and physical abuse were reactions to sexual abuse victimisation. A recent review found that it is common for multiple types of child abuse to co-occur and they are often correlated with each other. The studies included in this review that assessed multiple abuse victimisation identified a number of children suffering from co-occurring types of abuse, but they were not the majority. Knowledge of this finding is important for intervention design as shared variance between abuse types may influence the risk of abuse considerably (Herrenkohl & Herrenkohl, 2009). Further research is needed to investigate this phenomenon. Another identified household-level factor was large family units (2 studies). There is some debate in sub-Saharan Africa whether over-crowding may facilitate sexual abuse due to the necessity of co-sleeping and the lack of privacy (Dawes, 2002).

This review found conflicting results regarding ethnicity and race of sexual abuse victims as well as their location (rural versus urban). There appears to be unclear evidence regarding sexual abuse victims' ages in the studies within this review and in those from high income countries (Black et al., 2001b). Ethnicity and race could be important areas of future risk factor research.

Other factors associated with sexual child abuse on all levels of the Ecological Framework were also identified by this review (see results section). However, findings were limited to single studies and need to be investigated further.

Two of the reviewed studies also investigated multiple abuse victimisation. Correlates spanned all levels of the Ecological Framework. No reviews have been undertaken in high income countries regarding correlates of multiple abuse victimisation, and further research is needed to identify factors associated with multiple victimisation.

2.5.1 Limitations of this review

Surveys found in this review reported sample sizes from 94 to 126,696 adolescents. The sample sizes were large and powerful enough in most cases to yield statistical significance; however, some of the studies did not report *p*-values or odds ratios. Furthermore, studies used different types of analyses which ranged from χ^2 tests to multivariate logistic regressions to discriminant function analyses. Few reported adjusting for covariates, if any, and the number of variables within each model makes it difficult to compare results. Detailed reporting of analyses and variables used to model risk of child abuse should be a minimum requirement for future research on risk factors for child abuse victimisation.

The majority of studies were carried out with populations of high school or university students. While these are very valuable for establishing prevalence and correlates within this particular population, they can be problematic because they exclude vulnerable children and adolescents who might not be able to attend school or qualify for university. In 2008, the gross enrolment ratio for youth in secondary school in sub-Saharan Africa was 40%, and the ratio for tertiary education was 6% (UNESCO, 2010, 2012), suggesting that student populations are non-representative samples in some of the countries studied. These studies also exclude children who are too poor to pay for school fees, school uniforms or books in countries where these items are mandatory.

Only three of the reviewed studies addressed language and literacy issues within their sample population, translated and back-translated questionnaires in the local languages, and piloted questionnaires for comprehensibility for the sample population (Anderson & Ho-Foster, 2008; Cluver et al., 2011; Meinck et al., 2013). All other studies did not mention efforts to address literacy or language barriers. Low literacy rates in some of the surveyed populations may have an impact on the participants' ability to understand questions.

A further limitation of this review is the way abuse and the hypothesised associated factors were measured. Researchers used different scales; some were validated for the context in which they were used while others were self-constructed. Often there was no explanation for the development of child abuse scales. Many of the surveys did not distinguish between intra-familial and extra-familial abuse or only measured abuse occurrence without addressing frequency of abuse. It was therefore impossible to distinguish children who experienced one incident of abuse from children who experienced regular severe abuse. Moreover, abuse was defined differently in each study, which may also account for some of the variance in prevalence rates. A number of experiences which may be closely linked to child abuse such as bullying victimisation, intimate-partner violence, neglect, Munchhausen syndrome by proxy and corporal punishment in schools were excluded from this review. Further reviews could valuably synthesise the existing research evidence for these other forms of violence against children.

For the majority of surveys, it was unclear why certain factors were tested and others were not. These surveys did not provide theoretical frameworks or hypothesised theories of risk and protective factors. It would be of great value for future research to utilise empirical theoretical models in selecting and testing risk and protective factors. This would facilitate data comparison as studies would measure similar or identical correlates rather than random ones. It is also important to note that there are methodological challenges associated with different approaches to reporting abuse. Five of the surveys reviewed used adult retrospective-self-report. Evidence suggests this method may be subject to recall bias as participants may block out abusive memories or recall incidents incorrectly. If anything, there is a higher likelihood of under-reporting when using retrospective self-report (Hardt & Rutter, 2004).

There are also methodological concerns with regards to privacy of participants: ten out of 23 surveys were classroom-based and used child or adolescent self-report, but only two of these studies reported how they ensured confidentiality while filling in surveys within the classroom

setting. This again raises concerns about biased reporting in non-confidential settings. Incidents of abuse are likely to be even more under-reported than in other types of abuse research. In addition, no paper discussed the role cultural factors may play in abuse disclosure. It is possible that family structure, perpetrator-victim relationship and societal norms impact on the likelihood of abuse disclosure in the African context, as has been found in the West (Kenny & McEachern, 2000). Future research could valuably investigate if this is the case.

There were also concerns about unmeasured confounding variables in all studies. Due to the cross-sectional design of the studies, unmeasured confounding cannot be ruled out. Even though the majority of studies adjusted for potential confounding variables, model fit statistics were rarely reported. The way in which correlates of child abuse are inter-linked with each other and with other factors as well as the use of child-self report to measure correlates suggest a strong likelihood that important confounding variables concerning caregivers and extra-familial factors were not measured. Future research could valuably use matched caregiver-child data to address this issue.

Furthermore, the studies in this review were all at risk of selective reporting bias. Selective reporting occurs where researchers report on fewer outcomes than were originally measured or only give incomplete reports of outcomes measured (Hutton & Williamson, 2002). For trials, current best practice requires trial protocol registration in a trial registry prior to the commencement of the study in order to reduce selective reporting (World Medical Association, 2013), and many journals will refuse publication of results if this protocol was not followed. For observational studies, protocol registration is desired but not essential (Hemingway, Riley, & Altman, 2009), although calls for registration of observational studies are becoming more frequent (Loder, Groves, & MacAuley, 2010). None of the cross-sectional studies included in this review were registered, and it is therefore impossible to establish whether all measured outcomes were reported or not. This links to concerns regarding multiple comparisons carried

out in the analyses. None of the studies adjusted for multiple testing; however, knowledge about the number of analyses carried out is essential in order to interpret the results correctly as multiple comparisons increase the probability of statistical significance due to chance (Ioannidis, 2005).

In addition, all of the surveys identified were cross-sectional. They could not detect whether children had been subjected to abuse throughout childhood or whether the abuse was caused by a change in caregiver or family circumstances. Cross-sectional data do not allow for the establishment of directionality, although for most of the identified factors in these surveys, directionality was very unlikely to be reversible (i.e., child abuse would not precede parental low education, parental illness or parental HIV-status). Most studies referred to the correlates tested as risk factors even though the cross-sectionality of the data can merely test correlations not predictions (Murray et al., 2009). Some of the identified associated factors such as child helplessness, child disability, mental health problems or learning difficulties could be outcomes of child abuse rather than risk factors. Other parental factors such as parental cruelty and parental indifference might be part of the abuse pattern rather than risk factors. In addition, visible injuries on the child's body, described as a risk factor in one study, are almost certainly an outcome. In addition, one study found that having the mother employed as a prostitute or father employed as a trader were protective factors against physical or emotional abuse victimisation. These may not be protective factors but proxies for other unmeasured protective factors, such as higher family income or parental absence.

Of the hospital and social service case records reviewed, many were old and only described cases which had been reported to officials. These are therefore likely to be biased samples in light of the fact that low reporting of abuse occurs in all countries (Finkelhor, 1993). For the studies that only included abused children, comparison with children who did not report abuse did not occur.

There was a paucity of studies investigating correlates of physical abuse and in particular emotional abuse. The majority of surveys (17/23) examined sexual abuse. Due to the unavailability of research on correlates for physical and emotional abuse, few patterns could be identified for intervention design. In addition, few studies investigated protective factors, and no patterns for protective factors could be identified.

2.5.2 Implications for research, policy and practice

The findings of this review have implications for researching risk and protective factors for child abuse in Africa. The following recommendations for research are suggested by this review. i) Further research is needed with community-based samples using longitudinal data to establish prevalence rates and risk factors for child abuse. In particular, physical and emotional abuse remain little-understood. ii) Protective factors against abuse within both developing and developed world samples have been severely under-studied. It is essential that protective factors are rigorously investigated in order to understand how factors may interact with each other and to inform intervention design. iii) The majority of large scale studies within this review were carried out in South Africa and Egypt, two countries which are hardly representative for the majority of populations within Africa. Further investigation of risk and protective factors in other African countries is needed to establish whether and in what manner country-specific events such as epidemics, conflicts, wars, natural disasters, availability of social services, and different societal structures and cultures influence the child abuse burden of countries or have an effect on the risk and protective factors for child abuse (Cluver et al., 2011; McCrann, Lalor, & Katabaro, 2006; UNICEF, 2011a). iv) Further research is required to establish cultural correlates of child abuse and to identify modifiable risk and protective factors for child abuse on the African continent. v) To fully understand the context in which child abuse is occurring, future research could valuably focus on the relationship between child, perpetrator and the general family environment, particularly in cases where children have been orphaned or

abandoned. vi) Multiple abuse victimisation is vastly under-studied in African samples. Research from high income countries shows that many victims of child abuse experience more than one type of victimisation. These children are at higher risk of negative outcomes than children who have experienced a single traumatic event (Finkelhor, Ormrod, & Turner, 2007). Future research could valuably examine risk and protective factors for multiple abuse victimisation in order to help protect the most vulnerable of children. vii) Improving and standardising the methodological design of studies and reporting of results would facilitate future synthesis of available studies. viii) Strengthening and evaluating the available child protection systems within Africa is vital. Each state could develop a national strategy to address violence against children and prohibit all acts of violence against minors. Allocating resources to the prevention of child abuse and addressing the underlying causes of child abuse are important steps forward. Approaches could include the development of systematic training programmes for professionals and non-professionals working with children and families. Child participation in the process of developing child protection frameworks should be encouraged (United Nations, 2006). This has been successful in the development of child-friendly schools and learning environments and in the creation of adolescent reproductive health services in high income countries, ix) It is also unclear whether children know how to access available services and seek help to stop the re-occurrence of abuse. Further research is needed regarding the knowledge and help-seeking behaviour of child abuse victims as well as the response of professionals to referrals in abuse cases. x) Future research could valuably investigate the development and effectiveness of prevention interventions and services available for child victims of abuse. It is important that any parenting or child abuse prevention interventions developed for African countries be culturally sensitive, accessible and scalable for use with general and high-risk populations. In addition, it may be important to consider contextual factors such as patriarchal family structures, migrant labour, culturally specific traditions, extreme poverty, war, or HIV and other chronic illnesses.

The findings of this review also have implications for child protection policy and programming in Africa. Studies were too diverse to draw extensive evidence-based conclusions; however, it is clear that the high levels of child abuse shown in all studies require immediate attention by policy makers and child protection professionals.

Some indications about potential focus areas for interventions at many levels of the Ecological Framework were given by this review. Poor caregiver physical and mental health may be mitigated by improving availability, quality and access to primary healthcare, which provides holistic trauma-informed care (Ko et al., 2008). Improved caregiver health may also reduce the burden of substance abuse within families and communities. Furthermore, improved health service access might provide better treatment to victims of violence and their families. In addition, a functioning primary health service may be able to put screening processes in place to identify children at risk and those who have already been victimised. African governments have already pledged to allocate at least 15% of their annual budget to healthcare to achieve the Millennium Development Goals, a undertaking which the vast majority of countries have yet to achieve (World Health Organization, 2011).

Poor caregiver-child relationships can be addressed through parenting interventions. There is a strong evidence base from high income countries for the effectiveness of small group parenting programmes in reducing harsh parenting and child abuse (Mikton & Butchart, 2009). However, a recent systematic review of parenting interventions in the developing world found that few interventions to reduce harsh parenting have been tested in low income countries. Only four randomised-controlled trials have been completed in African countries, all with small samples, although these trials show promising results (Knerr, Gardner, & Cluver, 2011). Currently, there are few culturally sensitive child abuse interventions within African countries. Apart from state social services, a number of NGOs such as Childline, a free telephone hotline for children, or

Child Welfare South Africa provide services for young people in crisis⁶. A small number of child abuse prevention programmes focusing on family functioning and communication and parenting skills including the Sinovuyo Caring Families Project (<http://www.cwbsa.org/sinovuyo>), Africa Parenting Programme (http://www.aho.org.uk/africa_parenting.html), Win-Win Parenting (<http://www.winwinparenting.org/>) and Injabulo Families Programme exist or are in development (<http://www.cwbsa.org/families>). However, such services remain scattered and have not been scientifically evaluated thus far. An ongoing study in Burundi of the Urwaruka Rushasha Project showed a reduction of harsh parenting in its mid-term evaluation (Bundervoet, Annan, & Armstrong, 2011). However, final results are not yet available.

Prevention and treatment of child abuse can be costly. In countries where war, poverty and HIV/AIDS epidemics are major issues, limited resources may be available to address violence against children. However, a recent study carried out by the Centers for Disease Control found that in the United States alone, the estimated average cost per child abuse victim throughout their lifetime for healthcare, special education, criminal justice, productivity losses and child welfare is \$210,000 (Fang, Brown, Florence, & Mercy, 2012). The Australian Government estimated that they spent 0.45% of their GDP on the costs incurred by new incidents of child abuse in 2007 (Taylor et al., 2008). The costs of child abuse are therefore a considerable burden and comparable to the financial burden of infectious diseases. It is in the economic and ethical interests of policy makers to invest in prevention and treatment programmes (Bonnell, 2000). In countries where few or no services are provided, however, it will be difficult to calculate the cost of child abuse. Thus, it is vital to carry out these types of analyses within African countries to increase governmental awareness of the problem and to present policy makers with clear

⁶ Child hotlines are free to call from many mobile phones and landlines. Within sub-Saharan Africa, the majority of communities have standard pay phones in market squares operated by locals. In addition, according to the International Telecommunications Unit 63% of Africans have a mobile phone subscription (<http://www.itu.int/en/ITU-D/Statistics/Pages/stat/default.aspx>, 10/05/2013).

evidence of the economic importance of preventing child abuse. Recently, there has also been a movement towards generating an evidence base of prevalence studies, such as the Violence Against Children (VAC) studies, in several low- and middle-income countries series (Reza et al., 2009; UNICEF, 2011, 2012). This shows that child abuse research is gaining momentum in these countries and evidence is sought to frame policy agenda.

Training professionals, para-professionals and lay people to identify victims and children at risk for abuse as well as providing trauma-informed care to parents and children is vital to prevent and treat child abuse. To aid countries in setting up child abuse prevention systems, the World Health Organization has developed a screening tool which helps governments assess their readiness for implementing child abuse prevention strategies. Pilot testing is underway in a number of developing countries, and the tool is available online at no cost (World Health Organization, 2013).

Implementation of programmes to screen for and respond to child abuse will take time and will not be universal across the African continent. In general, protocols and guidelines should be established, detailing what services should be provided, how they should be provided and by whom. Protocols and standards will enable monitoring and evaluation of services. In addition, they will provide healthcare workers with knowledge about child abuse and important information about treating survivors. Once protocols and guidelines are in place, wide dissemination through the training healthcare workers, community outreach workers and the rest of the population can take place. Partnerships between primary healthcare facilities and specialist care facilities should be established for further referrals. There is currently little evidence from Africa regarding successful attempts to implement child protection services. However, the successful roll-out of other programmes, such as the testing and treatment campaign for HIV/AIDS, may present an excellent role model for child abuse prevention efforts.

Table 2-3: Description of included studies and hypothesized correlates

Author/Date	Country	Sample Characteristics	Report/scale used	Type of study	Types of Analyses carried out	Risk and protective factors	Prevalence	Definition of Abuse
Afifi, 2003	Egypt	555 children aged 12-18 years (mean 15.6)	Child self-report on all measures	Cross-sectional sample of school students	1. Univariate Logistic Regressions	<i>Physical Abuse:</i> Maternal disinterest OR 36.9 (CI 2.6-527), maternal education OR 22.3 (1.7-295), injury signs OR 688.3 (40.8-11614.1)	7.6%	beaten to the point of bruising, wounding, fractures or burns inflicted by an adult caregiver and confirmed through examination
			Physical abuse was confirmed by examination		2. Multivariate Logistic Regressions with factors found to be significantly associated in the first step.	Non-associated factors: gender, child hyperactivity, wasting, sharing bed with others, mistreatment by teacher, maternal employment, maternal illness, maternal cruelty, paternal cruelty, paternal incarceration, paternal disinterest, paternal predominance, paternal bad attitude towards mother, parental quarrels with child, disagreements between parents, problems in family, reward system child helplessness, child illness, child disability, child learning difficulties, living away from family father average education, father unwell and parental smoking		
			Self-designed abuse measure		3. Covariates adjusted for were: birth order and household crowding	<i>Emotional Abuse</i> Crowding OR 1.7 (1.1-2.7), child illness OR 4.7 (1.2-17.9)	12.3%	
						Non-significant factors: gender, Child helplessness, child hyperactivity, child learning difficulty, child living away from family, child mistreated by teacher, mother disinterested in child, father unwell, parents quarrel with child, problems within the family, arguments between parents, wasting, child disability, sharing bed with others, Injury signs, maternal education, maternal employment, maternal illness, maternal cruelty, paternal education, paternal cruelty, paternal disinterest, father in prison, paternal education, paternal predominance, paternal bad attitude towards mother, parental smoking, reward system		
						<i>Sexual Abuse:</i> Child-hyperactivity OR 11.8 (2.5-57.8), child disability OR 9.1 (1.6-50.6), maternal disinterest OR 48.6 (6.5-262.9), wasting OR 481.8 (10.7-21 734.1), school non-attendance OR 2.12 (1.6-282)	7%	
						Protective factors: high birth order of child OR 0.6 (0.4-0.9)	9.7%	Unwanted touching of private parts
						Non-significant factors: child helplessness, gender, living away from the family, child illness, child disability, child learning difficulty, sharing bed with others, mistreated by teacher, mother unwell, maternal education, maternal employment, maternal cruelty, paternal education, paternal illness, paternal cruelty, paternal predominance, paternal bad attitude towards mother, parental quarrelling with child, domestic disagreements, problems in the family, smoking, reward system, mother disinterested in child, father in prison, father disinterested in child		experienced at least two types of abuse (physical, emotional or sexual) in one child
						<i>Multiple-victimisation:</i> Parents quarrel with child OR 18 (2-164.3), paternal illness OR 30.6 (1.7-558.6), maternal illness OR 71.6 (3.3-1546.1), maternal cruelty OR 135.8 (0.9 –		

						19760.9), problems in family OR 53.7 (3.6-791.5), teacher maltreatment OR 40.3 (2.3-713.5), injury signs OR136.2 (5.8-3202.1)		
						Protective Factors: high birth order of child OR 0.2 (0.1-.07), paternal predominance OR 0.0 (0.0 – 0.01)		
						Non-significant factors: gender, wasting, child disability, maternal education, maternal employment, paternal education, paternal disinterest, parental smoking, child helplessness, child hyperactivity, child unwell, child learning difficulty, child living away from family, child sharing bed with others, visible injuries, maternal disinterest, paternal cruelty, father imprisoned, father has bad attitude towards mother, parents quarrel with child, arguments between parents		
Anderson et al., 2008	South Africa	126,696 male school children aged 10-19 (mean age 15)	Child self-report on all measures Self-designed abuse measure	Cross sectional survey	Multivariate Logistic Regression model which included all variables in the next column Unclear whether potential confounders were adjusted for	<i>Sexual Abuse:</i> Living in rural site areas OR 1.7 (1.42-1.99), living in less developed provinces (no OR), verbal insults (no OR), physical abuse OR 4.17 (3.1-5.18) Perpetrators: other schoolchildren, teachers, family members, other adults Non-significant factors: type of school, age, attitudes about sex, age at sexual debut, frequency of talk about sex, ever forced sex with someone else, believe condoms prevent HIV/AIDS, belief about personal HIV status	44%	Forced sex
Audu, et al., 2009	Nigeria	316 employed girls under the age of 18 (mean age 14.9)	Child self-report on all measures Self-designed abuse measure	Community based cross sectional sample of females involved in commercial activity	1. X ² tests were carried out 2. Significant variables were entered into multivariate Logistic Regression, see next column	<i>Sexual Abuse:</i> Being younger than 12 OR 3.55 (1.38-9.14), having more than 2 jobs OR 16.09 (4.19-61.69), working more than 8 hours OR 4.43 (1.59-12.29), having no formal education OR 4.79 (1.63-14.16) Protective factors: father's employment as a trader OR 0.05 (0.01-0.24) or senior civil servant OR 0.014 (0.001-0.31) and mother's employment as senior civil servant OR 0.26 (0.22 – 0.96) Non-significant factors: awareness of contraception, enrolment in school, wanting to go to school, living arrangements, relationship status of employer, place o employment and type of employment	77.7%	Forced sex
Ballet, et al., 2011	Mauretania	77 female street children (age not reported), recruited at two NGOs helping	Child self-report on all measures Self-designed abuse measure	Cross-sectional study, current self-report	Multiple correspondence analysis	<i>Physical and Emotional Abuse:</i> parents living together, father present in the household, father's employment, mother's employment, living in the city of Nouadhibou (no odds ratios given) Protective factors: absence of father, father employed as soldier, mother unemployed, mother working as prostitute, parents divorced or deceased, living in the city of Nouakchott	45.5% 16.9%	emotional harassment and ill-treatment by one's family Beatings which left marks

		destitute children						
Berard et al, 1999	South Africa	934 adolescents (15-22 years old)	Child-self report	Retrospective analysis of patient records at WSC adolescent outpatient psychiatric treatment centre admitted from February 1990 to April 1997	X^2 tests and t-tests to determine differences between abused and non-abused adolescents	<i>Sexual Abuse:</i> Living in a non-nuclear family ($p<.001$) and history of family alcohol abuse ($p=.031$)	33.9%.	Some form of contact sexual abuse including touching and penetration
Birdthistle, et al., 2011	Zimbabwe	1194 (90% female) aged 0-16 years	Child, caregiver and medical staff report as compiled in the records	Review of records of patients attending a child sexual abuse clinic	Multivariate Logistic Regressions adjusting for age	<i>Sexual Abuse:</i> double OR 1.8 (1.2-2.7), maternal OR 3.9 (2.4-6.3) and paternal orphanhood OR 1.3 (1.0-1.7)	94%	Forced sex
Breiding, et al.,	Swaziland	1244, 13-24 years females only	Child self-report on all measures	Cross-sectional, household survey	1. Bivariate Logistic Regressions to examine each risk factor	<i>Sexual Abuse:</i> Not being close to mother OR 1.88 (1.21-2.92), not attending school OR 2.12 (1.60-2.82), emotional abuse as child OR 2.06 (1.46-2.91), knowledge of other kids who were assaulted OR 1.59 (1.00-2.55), aware of children having sex with teacher OR 1.68 (1.21-2.34), greater number of people live with child OR 1.04 (1.01-1.07)	Prevalence rates from Reza et al 2009	
			LONGSCAN measures		2Multivariate Logistic Regressions of significant variables in step 1 adjusting for age, rural/urban location, socioeconomic status	Non-significant factors: death of a parent, abandonment by parent, parental education, quality of girl's relationship with parent, number of families child had lived with, frequency of visitors to the child's home, girl's level of trust in teachers, mode of travel to school, travel time to school, daily amount of time spent with friends, trust in neighbours, time spent fetching water or herding animals, ability to say no to sex with adult men, alcohol intake before the age of 13, had ever received information regarding sexual violence and early debut before 13 years of age	33.2%	Any sexual violence
							4.9%	Forced sex
							13.9%	Unwanted touching of respondent
							9%	Coerced sex
							18.8%	Attempted forced sex
							1.3%	Forced touching of perpetrator
					3. Backwards elimination of all non-significant risk factors			

Carey, et al., 2008	South Africa	94 (8.25-19 years) Youth Stress Clinic attendees, children who had experienced trauma	Child self-report on all measures	Cross-sectional survey among clinic attendees Childhood Trauma Questionnaire (CTQ)	1. X^2 and t-test to determine significant relationship between variables 2. Multinomial Logistic Regressions adjusting for age, ethnicity, and school grade	<i>Sexual Abuse:</i> Female gender OR 1.85 ($p<0.018$), single-parent families OR 6.69 ($p<0.006$), family receiving disability grant OR 1.58 ($p<0.05$) also associated with physical ($p=0.013$) and emotional abuse ($p<0.001$) Non-significant factors: social service support for family, parental employment, parents being alive, witnessing domestic violence, suspected parental substance abuse, living with stepfather	53% 48%	Contact sexual abuse Forced sex
Cluver, et al., 2011	South Africa	723 adolescents (mean age 16.9)	Child self-report on all measures UNICEF measures for national-level monitoring of orphans and vulnerable children, based on Parent-Child Conflict Tactic Scales	Longitudinal study but uses a cross sectional sample	Multivariate Logistic Regressions adjusting for gender, age, household size, forma./informal housing	<i>Physical Abuse:</i> Caregiver AIDS-Illness OR 2.25 (1.05-4.82), being orphaned by AIDS and living with a caregiver ill with AIDS (dually affected) OR 3.35 (1.36-8.26) Non-significant factors: being AIDS-orphaned, other orphanhood, other caregiver illness, healthy caregiver <i>Emotional Abuse:</i> AIDS-ill caregiver OR 2.26 (1.24-4.11), orphaned by AIDS OR 2.22 (1.25-3.95), dually affected (AIDS-ill caregiver and AIDS-orphaned) OR 3.93 (1.94-7.94) Non-significant factors: other orphanhood, other caregiver illness, healthy caregiver <i>Sexual Abuse:</i> Non-significant factors: other orphanhood, other caregiver illness, healthy caregiver, AIDS-ill caregiver, orphaned by AIDS, dually affected (AIDS-ill caregiver and AIDS-orphaned)	5% Healthy families 6% AIDS-orphaned 11% AIDS-ill caregiver 12% Dually affected 8% Healthy Family 15% AIDS-orphaned 13% AIDS-ill caregiver 23% dually affected Not stated	Beaten with an item likely to cause harm or hit so that it hurt or caused marks weekly or more often weekly or more frequent exposure to verbal abuse, threats to evict youth from home, or invoking evil spirits against youth Unwanted contact with "private parts" of the adolescent or abusing adult
Collings, 1991	South Africa	326 male undergraduate psychology students University of Natal (mean age 19.7 years)	Adult retrospective self-report Juvenile Victimization Questionnaire (JVQ)	Cross-sectional survey; adult self-report about childhood sexual abuse before the age of 17	Discriminant Function Analysis	<i>Sexual Abuse:</i> Being of black race, parental punitiveness, parental rejection, raised without father	28.9%	Contact sexual abuse including penetration and non-contact such as harassment

Collings, 1993	South Africa	200 children, 2 months to 17 years (mean 7.95 years) referred to Durban Child Welfare for alleged physical or sexual abuse in 1985-1988 white and coloured children only	Information provided by victims, family and social workers	Analysis of records of Durban Child Welfare	1. X^2 tests 2. Multiple Discriminant Function Analysis	<i>Physical Abuse:</i> younger victims, male gender, White race, younger parents, smaller family units, perpetrator biological parent not significant: mother married <i>Sexual Abuse:</i> Female gender, coloured background, perpetrator parent or family, large family units, older parents		Severe physical abuse Contact sexual abuse
Collings, 2005	South Africa	132 male children aged 1-17	Information provided by victims family, police and social workers	Review of all reported child sexual abuse incidents in North Durban from Jan 2001 to Dec 2003	Not stated	<i>Sexual Abuse:</i> Protective factor: Living with at least one biological parent OR .016 (0.03-0.85)		Contact sexual abuse
Dawes, et al., 2005	South Africa	925 South African families with children under 18	Parent self-report about use of corporal punishment Self-designed abuse measure	South African Survey of Attitudes toward corporal punishment, nationally representative sample	1. X^2 2. ANOVA only including attitude to corporal punishment, attitude to emphatic parenting	<i>Physical Abuse:</i> younger child age, older parental age, female parent, single and previously married, factors influencing the severity of corporal punishment: attitudes supportive of corporal punishment and attitudes towards non-empathic parenting	33%	Beaten with an object
Ibrahim, et al., 2008	Egypt	1897 female university students aged 18-24	Adult retrospective self-report ICAST-R for young adults	Cross-sectional study of prevalence and risk factors of child abuse	1. X^2 tests to determine significance 2. Multivariate Logistic Regression models which were adjusted but it is not stated what for	<i>Physical Abuse:</i> Mother's education less than university OR 1.26 (CR 1.1-1.5), domestic violence OR 2.64 (2.1-3.3) Non-significant factors: parental drug addiction, father's education less than university, parental mental health problems, and separation of parents. <i>Emotional Abuse:</i> Domestic violence OR 3.17 (2.44-4.11), parental mental health problems OR 1.53 (1.03-2.25)	45% 50.6%	exposed to at least one form of physical abuse such as kicked, burned, stabbed, hit with object, experienced at least one form of emotional abuse during childhood such as insulted or criticized, heard she wasn't loved, rejected,

Jewkes, et al., 2002	South Africa	11 735 women aged 15-49 years	Adult retrospective self-report	South Africa Demographic and Health Survey, cross-sectional analysis of longitudinal survey	Multiple Logistic Regression model	Non-significant factors: parental education less than university, parents separated, parental drug use,	2.9%	threatened to be killed, threatened to be abandoned	
							24.9%	Forced sex	
						Sexual Abuse: Mother's education less than university OR 1.57 (1.3-1.9), domestic violence OR 2.04 (1.4-2.4), parent's drug addiction OR 2.40 (1.3-4.3), parents not living together OR 1.82 (1.4-2.4)	25.8%	exposure to sexually inappropriate behaviour	
						Not significant factor: parental mental health problem, father's education less than university	13.2%	reported two forms of childhood abuse	
						Multiple victimisation: mother's education less than university OR 1.83 (1.36-2.47), domestic violence OR 2.54 (1.88-3.42), parental mental health problems OR 1.77 (1.12-2.76), parents not living together OR 1.62 (1.14-2.30)		experienced physical, emotional and sexual abuse combined	
						Non-significant factors: father's education less than university, parental drug problems Sexual Abuse: Age-cohort OR 0.74 (0.66-0.82), living in the Western Cape After adjusting for age and province: White OR 2.57 (1.41-4.69) Non-significant factors: ethnicity	1.6%	Forced sex	
King, et al., 2004	South Africa	939 aged 12-18 in grades 8 and 11 of high schools (mean 15.7 years)	Child self-report	Cross-sectional, school survey	1. X^2 tests	Sexual Abuse: Risk factors for girls: being female OR 3.85 (2.07-7.16), raised with biological parent and step-parent OR 2.59 (1.34-5.01), single parent OR 1.74 (1.00-3.04), antisocial behaviour OR 1.44 (1.12-1.86), having consumed alcohol OR 2.00 (1.10-3.62), suicidal behaviour OR 3.22 (1.65-6.20)	8.4%	Attempted forced sex	
			Self-designed abuse measure		2. Multivariate Ordinal Logistic Regression	Risk factors for boys: living with biological parent and step parent OR 7.82 (2.00–30.51)	5.8%	Forced sex	
					No information on adjustment for confounders	Non-significant factors: ethnicity, age, social amenities, and child consumption of drugs or cigarettes			
Madu, 2003	South Africa	722 undergraduate psychology students	Adult retrospective self-report	Cross-sectional study of university sample	Multivariate logistic regression analysis	Physical Abuse: Non-significant factors: not having lived with the biological mother, having lived with a step-parent before the age of 16	15.2%	Hit, slapped, punched, smacked, pulled hair or burnt at least once	
			Child Maltreatment				14.5%	Purposely hit, punched or injured	

		aged 15-47 (23.8 years)	t Interview Schedule (CMIS)		No information on adjustment for confounders			5%	Injured and needed medical attention
						<i>Emotional Abuse:</i> Living with stepfather or adoptive father before age 16 OR 2.30		26.9%	Any emotional abuse
						Non-significant factor: Not living with the biological mother			
						<i>Sexual Abuse:</i> Living with a step-father before the age of 16 OR 2.01		25.6%	reported any contact sexual abuse
						Protective factor: living with the biological mother before the age of 16 OR .039		13.6%	were forced to touch other's private parts or had their private parts touched
								8.7%	forced sex
Madu, et al., 2003	South Africa	722 undergradua te psychology students aged 15-47 (mean age 23.8 years)	Adult retrospective self-report Child Maltreatmen t Interview Schedule (CMIS)	Cross-sectional study of university sample	Multivariate logistic regression analysis No information on adjustment for confounders	<i>Physical Abuse:</i> Domestic violence OR 2.66, parental mental health problems OR 2.59 Non-significant factors: Parental drug problems, parent admitted to psychiatric unit		15.7%	Hitting, pushing, punching, cutting to leave bruises, fractures or bleeds
								14.5%	Purposefully hit, punched or injured
								5%	Hit so they needed medical attention
						<i>Emotional Abuse</i> Domestic Violence OR 4.30		26.9%	Any type of emotional abuse
						Non-significant factors: Caregiver mental health problems, caregiver substance abuse			
						<i>Sexual Abuse:</i> Parental mental health problems OR 2.69, parental drug and alcohol abuse OR 2.11		25.6%	Unwanted touching or kissing or penetration
						Non-significant factor: Domestic violence		13.6%	Unwanted intimate touching
								8.7%	Unwanted penetration
Madu, et al., 2002	South Africa	559 grade 9 & 10 high school	Child self- report	Cross-sectional study, adolescent	Multivariate Logistic	<i>Physical Abuse:</i> caregiver drug or alcohol abuse OR 2.26, witnessing domestic violence OR 2.56		22.5%	Any type of physical abuse such as punching, hitting, cutting,

		students aged 11-28 (mean age 17.4)	Child Maltreatment Interview Schedule (CMIS)	retrospective self-report	Regression Analysis	Non-significant factors: parental mental health problems		pushing, bruising, fractures, scratches or made to bleed
					No information on adjustment for confounders		10.4%	Needed medical attention
						<i>Emotional Abuse</i> Caregiver mental health problems OR 2.70, domestic violence OR 2.15	35.3%	Threatening to leave child in a frightening place, to hurt someone child cared about, to leave child, hurt child
						Non –significant factors: Parental drug abuse		
						<i>Sexual Abuse:</i> Domestic violence OR 2.02 , parental mental health OR 3.02	16.4%	Touching genitals or having to touch genitals
						Non-significant factors: Parental drug abuse, severe parental mental health problems	11.3%	Unwanted penetration
Madu, et al., 2000	South Africa	414 secondary school students in grade 9 and 10 aged 14-30 (mean age 18.5 years)	Child Self-report	Cross sectional study; adolescent retrospective self-report for sexual abuse experience before age 17	X ² tests	Risk factors: ethnicity (not Sotho), mother employed and not as labourer, step-parent present in the family	54.2%	any form of contact sexual abuse
			Child Maltreatment Interview Schedule (CMIS)			Non-significant factors: religion, paternal employment, paternal education, maternal education, family income, parents living together, paternal absence, and having supportive peers	28.9%	forced sex
Meinck et al., (2013)	South Africa	603 adolescents aged 13-19 (mean age 16.9) from a community based sample	Child Self-report	Cross-sectional study, current adolescent self-report of physical and emotional abuse experiences	1. Univariate Logistic Regressions	<i>Physical and/or Emotional Abuse:</i> family conflict OR 2.11 (1.30-3.42), unequal food distribution OR 2.96 (1.25-7), inconsistent discipline OR 2.01 (1.17-3.45), more than 3 caregiver changes OR 2.38 (1.14-5), living with a biological and a step-parent OR 4.36 (1.12-16.92), caregiver disability OR 1.10 (1.09-1.16), food insecurity OR 2.40 (1.29-3.21), bullying OR 2.74 (1.59-4.70), AIDS-related stigma OR 1.11 (1.05-1.17), sexual abuse OR 3.28 (1.36-7.90), school non-attendance OR 2.76 (1.35-5.65), school non-achievement OR 1.82 (1.13-2.93)	6.75% physical abuse	being hit by an object or hit so that it left marks on a weekly basis
			UNICEF measures for national-level monitoring of orphans and vulnerable children, based on Parent-Child Conflict Tactic Scales		2. Multiple Logistic Regression Models		11.9% emotional abuse	being insulted, threatened or frightened on a bi-weekly basis
					All regressions adjusted for age, gender, formal/informal housing and migration	Univariate Analyses: AIDS-orphaned OR 1.95 (1.24-3.07), caregiver unwell with AIDS OR 2.25 (1.28-3.95)		
						Protective factor: living with healthy caregiver		
						Non-significant factors: age of primary caregiver, living with biological parents, living with grandparents, orphaned by causes other than AIDS, living with a caregiver ill with chronic illness other than AIDS, being a double orphan, overcrowding, teacher support and social support		
Thurman, et al., 2011	South Africa	1782 children	Child self-report	Cross-sectional data from a	Multivariate logistic	<i>Physical and/or emotional abuse:</i>	25%	any threats or insults

Youssef, et al., 1998	Egypt	aged 10-17 participating in a longitudinal intervention study for OVCs in KZN	Self-designed abuse measure	longitudinal sample of children enrolled in an intervention study	regression analyses with all factors in the next column	Younger age (under 12) (no odds ratio), living with a chronically ill household member OR 1.32, parental presence OR1.77, living in a semi-urban area OR 2.46, poor caregiver mental health OR 1.20, poor family functioning OR 1.49, caregiver formal education OR1.4	32%	disciplined with a stick, belt etc,
		2170	Child self-report	Cross sectional data from school-based study	1. Univariate Logistic Regression Analyses	Non-significant factors: caregiver age, gender, marital status, number of children in the household, household poverty	13%	slapped, punched, hit
		secondary and middle school children aged 10-20 years (mean age 14.5)	Self-designed abuse measure		2. Multivariate Logistic Regression Analyses		43%	experienced any abuse
					No adjustment reported	<i>Physical Abuse:</i> Child factors: younger age OR 3.02 (2.50-3.65), higher birth order OR 1.05 (1.00-1.10), physical health problems and disability OR 2.59 (1.94-3.46), always disobedient OR 2.06 (1.67-2.54), disrespectful behaviour OR 2.14 (1.50-3.06), unable to communicate with parents OR 2.76 (2.30-3.32), repeating grades in school OR 1.91 (1.58-2.30), smoking OR 1.62 (1.08-2.43)	37.4%	any type of hitting or smacking, burns, tying up,
						Parental factors: were lower education of mother (primary/preparatory) OR 3.03, lower education of father (primary/preparatory) OR 2.99, parental substance abuse and smoking OR 1.45 (1.21-1.73), family arguments OR 2.07 (1.73-2.48), insufficient income OR 2.59, residence shared with strangers OR 1.65, overcrowding OR 1.14	25.8%	physical harm such as fractures
					Protective factors: maternal employment OR. 0.68 (.055-.087), father temporarily out of country for employment reasons OR. 0.27, family support OR 0.5 (.041-.062), sharing apartment with relatives OR 0.66, older child age OR 0.75 (0.71-0.79)			
						Non-significant factors: residence shared with strangers, family disruption through death or separation. Child factors which were not associated were contributing to the family income, destroying others belongings, running away from home		

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3 - Paper #2: Physical, emotional, and sexual abuse of children in South Africa: Incidence, prevalence, perpetrators, and locations

Under review: Child Abuse & Neglect



Picture: Urban area in Mpumalanga

This paper addresses the study questions on the nature and extent of child abuse in South Africa (research question 4). In the introduction, the paper summarises the best evidence currently available on prevalence rates for physical, emotional and sexual abuse victimisation and the context in which this study took place. It then details the aims and the methods and measures used in this study for data collection as well as the analytical approach. It describes the results in four additional sections. The first section illustrates the sample characteristics of the participants (n=3401) who completed the survey at baseline and follow-up. The second section details the findings on prevalence and incidence of child abuse victimisation. The third section describes socio-demographic characteristics which can put children at higher risk of abuse. The fourth section presents information on the perpetrators and locations of physical, emotional and

sexual child abuse victimisation. Finally, the results are summarised and placed in context with findings from other studies. In addition, policy and practice implications are considered.

Which research questions does this paper answer?

4. What are prevalence, incidence, perpetrators and locations of physical, emotional and sexual child abuse?

Abstract

Physical, emotional and sexual abuse of children is a major problem in South Africa, with severe negative outcomes for survivors. To date, no known studies have used data directly obtained from community-based samples of children to investigate prevalence, incidence, locations and perpetrators of child abuse victimisation. This information is essential to inform future interventions addressing child abuse. This study aimed to obtain estimates of prevalence and incidence, perpetrators and locations of physical, emotional and sexual child abuse in South Africa in a large community sample. Confidential self-report questionnaires were completed by children aged 10-17 (n=3515, 56.6 % female) using door-to-door sampling in randomly selected areas in two South African provinces. Follow-up surveys with the children were conducted a year later (96.7% retention rate). Abuse was measured using items from internationally used child abuse screening questionnaires. Prevalence was 16.6% for frequent physical abuse, 20.7% for frequent emotional abuse and 9% for lifetime contact sexual abuse amongst children in South Africa. Incidence was 11.8% for frequent physical, 10.3% for monthly emotional and 2.7% for contact sexual abuse. Perpetrators of physical abuse were mostly primary caregivers and teachers. For emotional abuse, perpetrators were predominantly primary caregivers and relatives. Perpetrators of sexual abuse were mostly girlfriend/boyfriends or other peers. There were high rates of monthly multiple abuse victimisation (0.6% to 9.2% depending on combinations of victimisation). This is the first study in South Africa to use a community-based sample and current child self-report. Findings showed high rates of physical, emotional and sexual abuse. Culturally and contextually appropriate interventions to prevent incidence and re-occurrence are necessary to minimise violence against children.

Abstract (250 words) – 270

Keywords: child abuse, physical abuse, emotional abuse, sexual abuse, multiple abuse victimisation, prevalence, incidence, South Africa, children, adolescents

3.1 Introduction

Evidence shows that victims of child abuse in sub-Saharan Africa have consistently poorer physical and mental health outcomes (Reza et al., 2009), are at increased risk for HIV infection (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010) exposure to transactional sex (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011), risk for re-victimisation (Jewkes, Levin, & Penn-Kekana, 2002), bullying (Cluver, Bowes, & Gardner, 2010), and poorer mental health (Brown et al., 2009; Cluver & Orkin, 2009). Little is known, however, about prevalence rates, perpetrators and locations of child abuse victimisation in South Africa, a country dealing with the impact of an HIV/AIDS epidemic and a society characterised by extreme inequality (World Bank, 2010).

Evidence of the epidemiology of child abuse in South Africa is limited and of varying methodological quality. Results, moreover, are inconsistent. Prevalence rates ranging from 6.7% to 32% are reported for physical abuse (Meinck, Cluver, Boyes, & Ndhlovu, 2013; Thurman & Kidman, 2011). Similarly, rates between 11.9% and 35.5% are reported for emotional abuse (Madu, Idemudia, & Jegede, 2002; Meinck et al., 2013). Rates between 1.6% and 60% are reported for sexual abuse (Jewkes, Levin, Mbananga, & Bradshaw, 2002; Madu & Peltzer, 2000). These differences in prevalence rates are due in part to differing definitions and measures for severity of abuse as well as differences in the samples used in each study (Meinck, Cluver, Boyes, & Mhlongo, 2014). Previous research on abuse in South Africa has had a number of limitations. To date, the majority of the evidence concerning child abuse comes from selective, often single-gender studies of university and high-school students (Anderson & Ho-Foster, 2008; Collings, 1991; Levett, 1989). These studies are liable to sampling bias, since lower income and more vulnerable children may be under-represented. Secondary-school enrolment is approximately 87% of the eligible population (Department of Basic Education, 2013), and only 18% of eligible South Africans are in tertiary education (Council on Higher Education, 2012). Importantly, emerging evidence suggests that children not attending school might be at particularly high risk of abuse (Meinck et al., 2013). Other studies exclusively

assess vulnerable children. Such studies can include samples from interventions for orphans and vulnerable children (OVC) (Thurman & Kidman, 2011). Some are community-based studies oversampling orphans (Meinck et al., 2013) or small-scale clinical case studies (Berard & Boermeester, 1999; Collings, 1993). Often these studies investigate only the most severe cases or the most vulnerable children using clinical reviews of cases reported to social services or children referred for psychological treatment. Finally, there are a number of retrospective studies from adult samples (Collings, 1991; Jewkes, Levin, Mbananga, et al., 2002). Caution must be applied to adult retrospective self-report of abuse, which is prone to recall bias, particularly where childhood memories are concerned (Chu, Frey, Ganzel, & Matthews, 1999; Fergusson, Horwood, & Woodward, 2000). In addition, retrospective studies only measure lifetime prevalence of abuse. All known studies to date are either cross-sectional or retrospective. Therefore, they cannot measure incidence of abuse.

This study is, to the authors' knowledge, the first to provide a descriptive examination of prevalence, incidence, location, perpetrators and severity of abuse in a longitudinal, community-based sample of children in South Africa.

3.2 Objectives

This study aims to establish i) the prevalence and frequency of physical, emotional, sexual and multiple child abuse victimisation in a community-based sample of youth, ii) the incidence of physical, emotional and sexual victimisation in this sample; iii) differences in abuse victimisation by gender, age and rural/urban location, and iv) perpetrators and locations of different types of physical, emotional and sexual child abuse victimisation within this sample.

3.3 Methods

3.3.1 Participants

At baseline, children aged 10-17 ($n = 3515$) were recruited from two urban and rural health districts with >30% HIV-prevalence in two provinces: Mpumalanga and the Western Cape (Department of Health, 2009). In each district, census enumeration areas were randomly selected. Within each area, door-to-door sampling was used, and every household with a resident adolescent was included. Where households included more than one resident adolescent, one was randomly selected to participate. Refusal rate at baseline was 2.8% and <.5% at follow-up. Baseline data collection took place between January 2010 and June 2011. A year later, 3401 (96.7%) of participants were traced and re-interviewed.

3.3.2 Procedures

Participants completed confidential questionnaires which were translated into Xhosa, Swati, Tsonga, Northern Sotho and isiZulu and checked with back translation. Interviewers assisted participants in filling out the questionnaires, which took 60 minutes to complete. Children were interviewed in locations of their choice, such as spare class rooms in schools or under a secluded tree, which guaranteed confidentiality. Children participated in the language of their choice. Interviewers received intensive training in working with vulnerable children and in administering standardised questionnaires. All survey items were pre-piloted with vulnerable youth to investigate age-appropriateness and cultural sensitivity. Stringent quality checks were in place so that missing data were <.5%.

Ethical approval was granted by the Universities of Oxford, Cape Town and KwaZulu-Natal; the National Department of Social Development; and the Western Cape and Mpumalanga provincial Departments of Health and Education.

Informed consent was sought from both children and their caregivers. Due to low literacy in the sampled population group (Department of Basic Education, 2012; Howie, van Staden, Tshele, Dowse, & Zimmerman, 2012), information and consent sheets were read out loud and clarification questions were answered until participants were satisfied and consented to take part. Participation was voluntary, and children were able to stop the interview at any time. All participants received a certificate and light refreshments irrespective of completion of the questionnaire.

Confidentiality was maintained throughout the study unless participants were considered at risk of significant harm or requested help. In these cases, the project manager and interviewer discussed referral options with the child. Following that, immediate referrals were made to local child protection services for children, with follow-up support by interviewers. For children who had experienced abuse in the past, referrals to counselling centres and HIV-testing services were made where appropriate and requested. A total of 664 referrals were made.

3.3.3 Measures

3.3.3.1 Child physical and emotional abuse victimisation

Child physical and emotional abuse victimisation were measured using five items from the UNICEF Measures for National-level Monitoring of OVC (Snider & Dawes, 2006). It has been used in South Africa and showed good reliability of $\alpha=.70$ (Meinck et al., 2013). Seven additional items were designed and tested for follow-up data collection with the help of local social workers, NGO staff working with OVC, and adults and children from the local community (all items listed in Table 3-1). The overall reliability for this 14-item scale was $\alpha=.74$.

Table 3-1: Questionnaire items for Child physical and emotional abuse victimisation

Source:	Questionnaire items:
UNICEF Measures for National-level Monitoring of Orphans and Other Vulnerable Children	How often in the past year did an adult... 1) use a stick, belt or other hard item to hit you? 2) slap, punch or hit you so that it hurt? 3) threaten to send you away or kick you out of the house? 4) threaten to invoke ghosts or evil spirits or harmful people? 5) call you dumb, lazy or other names? 6) withhold a meal to punish you?* 7) single you out to do household chores all day instead of school or play?* Items design by local social workers, NGO staff, children from the local community. 8) make you stand or kneel in an uncomfortable position for a long period of time to punish you?* 9) threaten to hurt you or give you bad grades?* 10) insult members of your family that have passed away?* 11) threaten to leave you and never come back?* 12) make you feel unwelcome at home?* 13) threaten to hurt or kill a person or an animal that you care about?*
*Administered at follow-up assessment only.	

3.3.3.2 Child sexual abuse victimisation

Child sexual abuse victimisation at baseline was measured using two items designed by social workers in South Africa and one item from the National Survey of HIV and Risk Behaviour Amongst Young South Africans (Pettifor et al., 2005). All baseline sexual abuse items measured lifetime exposure with a no/yes response code. Sexual abuse victimisation at follow-up was measured in more detail using five items from the Juvenile Victimization Questionnaire (Finkelhor, Hamby, Ormrod, & Turner, 2005). Items were modified to fit the cultural context with the help of experienced social workers and were then pre-piloted with children in South

Africa (all items are listed in Table 3-2). Contact sexual abuse was defined as any unwanted touching or kissing, touching of private parts and/or forced sex.

For all abuse items administered at follow-up and for physical and emotional abuse at baseline, participants were asked to state frequency of abuse in the past year (never, happened but not last year, at least once, monthly, and weekly). All follow-up items also measured the relationship of the perpetrator to the child and the location of the abuse. The whole abuse measure showed good reliability in this sample ($\alpha = .73$).

To get a sensitive estimate of incidence for monthly or more frequent occurrence of the three types of abuse, individual questionnaire items for physical, emotional and sexual abuse were coded into dichotomous variables. If the child did not report monthly or more frequent victimisation at baseline or follow-up, or if the child mentioned victimisation at both baseline and follow-up, the response was coded as 0. If any type of weekly or monthly victimisation was mentioned at follow-up but not at baseline, this was coded as 1. To allow comparability across the two measurement points, the original baseline measures were used to determine incidence. Similarly, dichotomous variables were created for prevalence at follow-up in each abuse category (0: *not abused*; 1: *abused*). Prevalence was further divided to reflect lifetime abuse, past-year abuse, monthly abuse and weekly victimisation.

3.3.3.3 Perpetrators and locations of abuse victimisation

Participants were able to identify the perpetrator for each abusive act they had experienced. The options were: Caregiver, teacher, relative, neighbour or 'other'. For 'other', further clarification on the relationship status for the child was asked for.

Participants also had the option of clarifying the location in which they had been victimised. The options were: Home, community, school, home of neighbour and 'other'. For 'other', further clarification of the location was asked for.

Table 3-2: Questionnaire items for child sexual abuse victimisation

Source:	Question:
Baseline:	
National Survey of HIV and Risk Behaviour:	“Have you ever had sex with someone when you didn’t want to because they hurt you, or you were afraid that they were going to hurt you if you didn’t?”
Local social workers:	Has anyone ever...
	1) touched you in a way that made you feel uncomfortable?
	2) made you do something with your private parts or their private parts that you did not want to?
Follow-up:	
Juvenile Victimization Questionnaire	How often in the past year did someone...
	1) tell you that you look sexy in a way that made you feel uncomfortable?
	2) force you to watch sexual things or pictures with nude images?
	3) touch or kiss you in a way that made you feel uncomfortable?
	4) touch your private parts or asked you to touch their private parts even though you did not want this to happen?
	5) force you to have sex with them in any way when you did not want to?

3.3.3.4 Multiple abuse victimisation

Multiple abuse victimisation was defined as a positive response to more than one category of abuse. It was measured by combining the dichotomous variables of physical and emotional abuse and contact sexual abuse, and then creating dichotomous variables of two or more concurrent abuse types versus one or none. These resulted in the binary variables ‘physical, emotional and sexual abuse’, ‘physical and emotional abuse’, ‘physical and sexual abuse’ and ‘emotional and sexual abuse’ (0: *not experienced multiple abuse victimisation*; 1: *experienced multiple abuse victimisation*).

3.3.3.5 Socio-demographics

Socio-demographics such as gender, age, and location (urban or rural) were measured using items modelled on the South African Census (Statistics SA, 2001).

3.3.4 Analyses

Descriptive analyses were conducted using SPSS 20. Estimates of incidence and prevalence of physical, emotional and sexual abuse as well as multiple abuse victimisation were assessed. Perpetrators and locations of perpetration were also examined. Prevalence rates were tested for demographic differences using Pearson's χ^2 -tests. Due to the large number of comparisons, a conservative alpha level was set ($p < .001$).

3.4 Results

The analysis included 3515 children at baseline (56.7% female, mean age 13.45 years) and 3401 children (96.7% retention rate) at follow-up (54.5% female, 14.67 years). Approximately half lived in urban areas (50.6% at baseline, 48.6% at follow-up) (Table 3-3).

Table 3-3: Socio-Demographic Characteristics

	Baseline (n= 3515)	Follow-up (n = 3401)
Gender	56.7% (1992) female	54.6% (1919) female
Rural or Urban	50.6% (1778) urban	48.6% (1709) urban
Province	47.3% (1664) Mpumalanga	46.9% (1648)Mpumalanga
Mean age	13.45 years	14.67 years

3.4.1 Prevalence and Incidence

Physical Abuse: At follow-up, 56.3% of children reported lifetime physical abuse, 37.9% reported past-year physical abuse, 16.6% reported monthly physical abuse and 7.4% reported weekly physical abuse in the last year. Incidence of monthly physical abuse between baseline and follow-up was 11.8% (Table 3-4).

Emotional abuse: At follow-up, 35.5% of children reported lifetime emotional abuse, 31.6% reported past-year emotional abuse, 20.7% reported monthly emotional abuse and 12.4% reported weekly emotional abuse in the last year. The incidence of monthly emotional child abuse between baseline and follow-up was 10.3% (Table 3-4).

Sexual Harassment: At follow-up, 14.3% of children reported lifetime sexual harassment, 12.8% reported past-year, 8.1% reported monthly and 4.6% reported weekly sexual harassment. As sexual harassment was not measured at baseline, incidence of sexual harassment was not calculated.

Forced to watch pornography: At follow-up, 2.4% of children reported having been forced to watch pornographic material in their lifetime. 2% reported past-year, 0.8% reported monthly and 0.4% reported weekly unwanted exposure to pornographic material (Table 3-4).

Sexual abuse: At follow-up, 9% of children reported lifetime contact sexual abuse or rape, 5.9% reported past-year, 2.8% reported monthly and 1.5% reported weekly contact sexual abuse. In addition, 3.3% of all children had experienced rape. 0.8% reported past-year, 0.3% reported monthly and 0.2% reported weekly rape victimisation. The incidence of past year contact sexual abuse at follow-up was 2.7% (Table 3-4).

3.4.2 Multiple Abuse Victimisation

Physical, emotional and sexual abuse: At follow-up, 3.2% of participants reported past year, 0.6% reported monthly and 0.3% reported weekly physical, emotional and sexual abuse (Table 3-4).

Physical and emotional abuse victimisation: At follow-up, 19.6% of participants reported past-year, 9.2% reported monthly and 4.2% reported weekly physical and emotional abuse (Table 3-4).

Table 3-4: Prevalence rates of physical, emotional and sexual child abuse victimisation

	Weekly or more frequent % (n)	Monthly or more frequent% (n)	In the last year %(n)	Not in the last year % (n)	Ever % (n)	Incidence % (n)
Physical Abuse (CPA)						
Baseline	10.1% (345)	18.2% (619)	40.1% (1365)	--	--	--
Follow-up	7.4% (250)	16.6% (564)	37.9% (1289)	22.7% (773)	56.3% (1916)	11.8% (401)
Emotional Abuse (CEA)						
Baseline	10.6% (362)	19.2% (654)	34.1% (1160)	--	--	--
Follow-up	12.4% (423)	20.7% (704)	31.6% (1076)	7.4% (250)	35.5% (1206)	10.3% (351)
Sexual Harassment						
Baseline	--	--	--	--	--	--
Follow-up	4.6% (155)	8.1% (276)	12.8% (437)	1.9% (65)	14.3%	--
Forced Exposure to Pornography						
Baseline	--	--	--	--	--	--
Follow-up	0.4% (13)	0.8% (26)	2% (69)	0.4% (13)	2.4% (82)	--
Contact Sexual Abuse (CSA)						
Baseline	--	--	--	--	3.7% (125)	--
Follow-up	1.5% (50)	2.8% (94)	5.9% (201)	2.2% (74)	9% (306)	2.7% (97)
Rape						
Baseline	--	--	--	--	1.2% (41)	--
Follow-up	0.2% (7)	0.3% (10)	0.8% (28)	0.7% (25)	3.3% (111)	--
Multiple Abuse						
CPA, CSA & CEA	0.3% (11)	0.6% (22)	3.2% (109)	0.5% (16)	4.6% (155)	--
CPA & CEA	4.2% (144)	9.2% (312)	19.6% (667)	3.7% (127)	27.1% (922)	--
CPA&CSA	0.5%(16)	0.8% (28)	3.6 % (122)	0.9% (30)	6.1% (209)	--
CEA& CSA	0.6% (20)	1.6% (56)	3.6% (123)	0.7% (25)	5.6% (190)	--

Physical and sexual abuse victimisation: At follow-up, 3.6% of participants reported past-year, 0.8% reported monthly and 0.5% reported weekly physical and sexual abuse (Table 3-4).

Sexual and emotional abuse victimisation: At follow-up, 3.6% of children reported past-year, 1.6% reported monthly and 0.6% reported weekly emotional and sexual abuse (Table 3-4).

Demographic differences in prevalence rates for all abuse types are described in Table Table 3-5 and Table 3-6.

3.4.3 Perpetrators and locations of abuse

Perpetrators of physical abuse victimisation were most commonly primary caregivers, followed by teachers and relatives (Table 3-7). Perpetrators for emotional abuse were most commonly primary caregivers, followed by relatives and teachers. The most common locations for physical and emotional abuse were the home, followed by schools and communities. Perpetrators of sexual incidents (harassment, forcing participants to watch pornography, unwanted sexual touching or kissing, unwanted genital touching) were most commonly friends and intimate partners. Forced sex was mainly perpetrated by strangers, relatives and intimate partners. The locations for sexual harassment, being forced to watch pornography, unwanted sexual touching and unwanted genital touching were primarily the community and school. Forced sex was mostly reported to have happened in the community and in the home (Table 3-7).

Table 3-5: Differences in abuse victimisation by gender, rural urban and age

	Male/Female	Urban/Rural	11-14/15+
Physical Abuse			
Weekly	2.8% (96)/ 4.5% (154)	2.5% (85)/ 4.9% (165)***	4% (137)/3.3% (113)
Monthly	7.4% (253)/ 9.1% (311)	7.3% (249)/ 9.3% (315)	9.4% (318)/ 7.2% (246)***
In the last year	17% (577)/ 20.9% (712)	17.6% (600)/ 20.3% (689)	20.3% (691)/17.6% (589)***
Not in the last year	10.1% (345)/12.6% (428)	12% (408)/ 10.7% (365)	10.7% (365)/12% (408)
Ever	25.2% (856)/ 31.2% (1060)	27.8% (946)/ 28.5% (970)	29.1% (988)/27.3% (928)***
Emotional Abuse			
Weekly	4.7% (161)/ 7.7% (262)	5.3% (181)/ 7.1% (242)***	5.8% (197)/6.6% (226)
Monthly	7.9% (268)/ 12.8% (436)***	9.6% (326)/ 11.1% (378)	9.5% (322)/11.2% (382)
In the last year	12.6% (428)/ 19.1% (648)	15% (509)/ 16.7% (567)	14% (475)/ 17.7% (601)
Not in the last year	3.1% (105)/ 4.3% (145)	3.8% (129)/ 2.6% (121)	3.4% (115)/4% (135)
Ever	14.3% (458)/ 21.2% (721)	16.9% (576)/ 18.5% (630)	15.8% (538)/19.6% (668)
Sexual Harassment			
Weekly	2.2% (32)/6.4% (120)***	4.1% (68) /5.1% (84)	2.4% (39)/6.7% (113)***
Monthly	4.7% (68)/10.7% (202)***	7.5% (123)/9.0% (147)	4.4% (71)/11.8% (199)***
In the last year	7.2% (102)/ 17.2% (324)***	12.3% (203)/13.6% (223)	7.5% (120)/18.1% (306)***
Not in the last year	1.4% (19)/2.3%(41)	1.8% (29)/ 1.9% (32)	1.4% (23)/2.2% (37)
Ever	8.6% (124)/ 19.5% (365)***	14.1% (232)/15.5% (254)	8.9% (143)/20.3% (343)***
Pornography			
Weekly	0.5% (7)/0.3% (6)	0.3% (5)/0.5% (8)	0.2% (3)/0.6% (10)
Monthly	0.8% (11)/0.8% (15)	0.5% (9)/1% (17)	0.6% (10)/0.9% (16)
In the last year	1.7% (25)/2.3% (43)	1.6 (26)%/2.5% (42)	1.4% (23)/2.7% (45)
Not in the last year	0.3% (4)/0.4% (8)	0.5% (8)/0.2% (4)	0.3% (5)/0.4% (7)
Ever	2% (29)/2.8% (51)	2.1% (34)/2.7% (46)	1.8% (28)/3%* (52)
Sexual Abuse			
Weekly	0.6% (20)/ 0.9% (30)	0.5% (18)/ 0.9% (32)	0.4% (14)/1.1% (26)
Monthly	1% (35)/ 1.7% (59)	1% (34)/ 1.85 (60)	0.8% (27)/2% (67)***
In the last year	1.8% (61)/ 4.1% (140)***	2.5% (84)/ 3.4% (117)	1.8% (60)/4.1% (141)***
Not in the last year	0.8% (26)/ 1.4% (48)	1% (34)/ 1.2% (40)	0.7% (25)/1.4% (49)
Ever	3% (101)/ 6% (205)***	4.1% (140)/ 4.9% (166)	2.6% (87)/6.4% (210)***
Rape			
Weekly	0.1% (2)/ 0.3% (5)	0.2% (3)/ 0.2% (4)	0.1% (2)/ 0.3% (5)
Monthly	0.1% (2)/ 0.4% (8)	0.3% (5)/ 0.3% (5)	0.2% (3)/ 0.4% (7)
In the last year	0.2% (3)/ 1.3% (25)***	0.8% (14)/ 0.8% (14)	0.6% (9)/ 1.1% (19)
Not in the last year	.02% (3)/ 1.1% (22)***	0.7% (12)/ 0.8% (13)	0.6% (10)/ 0.8% (15)
Ever	2% (29)/ 4.3% (82)***	3.5% (60)/ 3.0% (51)	1.7% (27)/ 4.7% (84)***
Pearson's chi-square test (2 tailed): p<0.001 ***			

Table 3-6: Differences in multiple abuse victimisation by gender, rural urban and age

	Male/Female	Urban/Rural	11-14/15+
CPA, CSA & CEA		0% (1)/ 0.3% (10)	0.1% (3)/ 0.2% (8)
Weekly	0.1% (3)/ 0.2% (8)	0.2% (8)/ 0.4% (14)	0.2% (6)/ 0.5% (16)
Monthly	0.2% (7)/ 0.4% (14)	1.4% (46)/ 1.9% (63)	1.2% (40)/ 2% (69)
In the last year	0.9% (31)/ 2.3% (78)***	0.3% (9)/ 0.2% (7)	0.2% (7)/ 0.3% (9)
Not in last year	0.2% (8)/ 0.2% (8)	2.1% (72)/ 2.4% (83)	1.6% (53)/ 3% (102)***
Ever	1.5% (50)/ 3.1% (105)**		
CPA&CEA		1.3% (43)/ 3% (101)***	2.3% (77)/ 2% (67)
Weekly	1.4% (48)/ 2.8% (96)	3.7% (126)/ 5.5% (186)***	4.9% (166)/ 4.3% (146)
Monthly	3.5% (119)/ 5.7% (193)	8.7% (295)/ 10.9% (372)***	9.3% (316)/ 10.3% (351)
In the last year	8% (272)/ 11.6% (395)	2.1% (72)/ 1.6% (55)	1.5% (51)/ 2.2% (76)
Not in last year	1.6% (56)/ 2.1% (71)	12.9% (438)/ 14.2% (484)	12.6% (429)/ 14.5% (493)
Ever	11.3% (383)/ 15.8% (539)		
CPA & CSA		0.1% (4)/ 0.4% (12)	0.2% (6)/ 0.3% (10)
Weekly	0.2% (6)/ 0.3% (10)	0.3% (11)/ 0.5% (17)	0.3% (9)/ 0.6% (19)
Monthly	0.3% (10)/ 0.5% (18)	1.4% (49)/ 2.1% (73)	1.3% (43)/ 2.3% (79)
In the last year	1.1% (37)/ 2.5% (85)	0.4% (14)/ 0.5% (16)	0.3% (11)/ 0.6% (19)
Not in last year	0.4% (13)/ 0.5% (17)	2.8% (95)/ 3.4% (114)	2.0% (69)/ 4.1% (140)***
Ever	2.1% (72)/ 4% (137)		
CEA& CSA		0.2% (6)/ 0.4% (14)	0.1% (3)/ 0.5% (17)
Weekly	0.2% (6)/ 0.4% (14)	0.6% (20)/ 1.1% (36)	0.4% (15)/ 1.2% (41)
Monthly	0.5% (16)/ 1.2% (40)	1.5% (52)/ 2.1% (71)	1.1% (39)/ 2.5% (84)***
In the last year	0.9% (30)/ 2.7% (93)***	0.4% (12)/ 0.4% (13)	0.4% (12)/ 0.4% (13)
Not in last year	0.3% (10)/ 0.4% (15)	2.5% (86)/ 3.1% (104)	1.8% (62)/ 3.8% (128)***
Ever	1.7% (57)/ 3.9% (133)***		
Pearson's chi-square test (2 tailed): p<0.001 ***			

3.5 Discussion

This is the first large scale community-based study examining incidence and prevalence of child abuse victimisation in South Africa. It adds valuable information regarding perpetrators, locations, incidence and prevalence rates of physical, emotional and sexual child abuse to the current literature. In addition, no other published study in South Africa has investigated multiple abuse victimisation. This is an important dimension, since studies in other countries have shown that a large number of child abuse victims are subject to multiple types of abuse (Finkelhor, Ormrod, & Turner, 2007) and that they tend to have poorer mental and physical health outcomes than victims of single types of abuse (Felitti et al., 1998; Ford, Elhai, Connor, & Frueh, 2010).

3.5.1 What are prevalence and incidence rates of physical, emotional and sexual child abuse in South Africa?

Overall, participants reported a high incidence of physical (11.8%), emotional (10.2%) and contact sexual abuse (2.7%). High prevalence of monthly physical (16.6%) and emotional (20.7%) abuse, lifetime contact sexual abuse including rape (9%) and lifetime rape (3.3%) were also reported. Participants also reported past-year multiple abuse victimisation of physical and emotional abuse (19.6%); emotional and contact sexual abuse (3.6%); physical and contact sexual abuse (3.6%); and physical, emotional and contact sexual abuse (3.2%). Girls and older children were found to be at particular risk.

In general, other recent studies show higher rates for physical, emotional and sexual abuse victimisation in children of comparable age groups (13-17) than this current study (age group 10-17); in particular for sexual victimisation (UNICEF, 2012; UNICEF, 2011). The Violence against Children study in Kenya found that 10.7% of females and 4.2% of males had experienced sexual abuse and 48.7% of females and 46.8% of males experienced physical abuse in the past year. Emotional abuse was not measured in this age group (UNICEF, 2012). The Tanzanian study found 14% prevalence of past year sexual abuse in females and 5.9% in males. 51.1% of females and 51% of males reported past year physical abuse. Emotional abuse was not measured for this age group (UNICEF, 2011). The VAC study from Swaziland found past year sexual abuse victimisation to be 16% in females. Lifetime physical abuse victimisation was 28.1% and lifetime emotional abuse victimisation 33.3% (Reza et al., 2007) which is lower than in this current study.

However, studies with older adolescents tend to have higher lifetime and past year prevalence rates of sexual abuse victimisation as the risk for victimisation increases in the last teens as shown by this current study and the studies from Tanzania and Kenya, where the highest incidence of sexual abuse victimisation was in the age group 16-17, which is two years older than the mean age of this current study (UNICEF, 2012; UNICEF, 2011). While

all three VAC studies do not report the mean age of the participants, the minimum age for recruitment was two years older than for this current study which increases the likelihood of a higher mean age of the populations studied.

While comparisons of child abuse victimisation are difficult and problematic due to measurement issues (Besharov, 1981; Hulme, 2004; Kinard, 1994), the similar findings across studies in these Eastern and Southern Africa suggest very high rates in these regions in comparison with studies from high income countries which generally show much lower rates (Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000; Finkelhor & Dzuiba-Leatherman, 1994; May-Chahal & Cawson, 2005; Radford, Corral, Bradley, & Fisher, 2013).

Table 3-7: Perpetrators and locations of child abuse victimisation

Type of Abuse	Perpetrators	Percentage	Locations	Percentage
Use stick belt or hard item	Caregiver	62.7%	Home	72.5%
	Teacher	24.5%	School	25.2%
	Relative	8.1%	Community	2.1%
	Neighbour	0.6%	Home of neighbour	0.1%
	Other	4.1%	Other	0.1%
Make stand or kneel in uncomfortable position	Caregiver	24.2%	Home	31.1%
	Teacher	62.4%	School	62.4%
	Relative	8.5%	Community	5.1%
	Neighbour	1.7%	Home of neighbour	1.1%
	Other	3.1%	Other	0.3%
Slap, punch, hit pinch, hurt or had marks	Caregiver	42.8%	Home	58.9%
	Teacher	30.3%	School	31.4%
	Relative	14.4%	Community	8.9%
	Neighbour	2.6%	Home of neighbour	0.4%
	Other	9.8%	Other	0.5%
Single out to do chores	Caregiver	68.4%	Home	86.4%
	Teacher	8.4%	School	8.3%
	Relative	15.4%	Community	3.8%
	Neighbour	2.3%	Home of neighbour	1.5%
	Other	5.7%	Other	0%
Threaten to hurt or give bad grades	Caregiver	33.5%	Home	44.5%
	Teachers	37.3%	School	38.7%
	Relatives	10.8%	Community	14.2%
	Neighbour	7%	Home of neighbour	1.3%
	Other	11.4%	Other	1.3%
Call ghost or evil spirits	Caregiver	51.9%	Home	72.4%
	Teacher	3.8%	Community	15.2%
	Relative	18.3%	School	9.5%
	Neighbour	6.7%	Home of neighbour	2.9%
	Other	19.2%	Other	0%
Make you feel burden	Caregiver	57.8%	Home	88.8%
	Teacher	1.7%	School	2.2%
	Relative	30.6%	Community	7.3%
	Neighbour	1.7%	Home of neighbour	1.1%
	Other	8.3%	Other	0.6%
Make you feel unwelcome	Caregiver	70.1%	Home	95.1%
	Teacher	1.3%	School	1.3%
	Relative	22.1%	Community	2.8%
	Neighbour	1.3%	Home of neighbour	0.4%
	Other	5.2%	Other	0.4%
Threaten to kick out of the house	Caregiver	74.6%	Home	93.7%
	Teacher	1%	School	2.1%
	Relative	18.6%	Community	3.8%
	Neighbour	0.7%	Home of neighbour	0.3%
	Other	5.2%	Other	0%
Insulting child	Caregiver	71.7%	Home	89.7%
	Teacher	3.2%	School	4.6%
	Relative	16.4%	Community	4.8%
	Neighbour	3%	Home of neighbour	0.3%
	Other	5.7%	Other	0.6%
Insult dead family members	Caregiver	49%	Home	77.1%
	Teacher	1.4%	School	4.9%
	Relative	24.1%	Community	15.3%
	Neighbour	11.7%	Home of neighbour	2.1%
	Other	13.8%	Other	0.7%

Threaten to leave and never comeback	Caregiver	72.5%	Home	90.1%
	Teacher	0.7%	School	1.4%
	Relative	16.9%	Community	7.7%
	Neighbour	4.2%	Home of neighbour	0.7%
	Other	5.6%	Other	0%
Threaten to hurt or kill a person or animal	Caregiver	40.2%	Home	64.6%
	Teacher	2.9%	School	7.1%
	Relative	26.5%	Community.	25.3%
	Neighbour	11.8%	Home of neighbour	3.0%
	Other	18.6%	Other	0%
Withhold a meal to punish	Caregiver	57.8%	Home	79.5%
	Teacher	3.9%	School	9.1%
	Relative	20%	Community	10.8%
	Neighbour	4.4%	Home of neighbour	0.6%
	Other	13.3%	Other	0%
Sexual harassment	Caregiver	2.4%	Home	9.7%
	Teacher	1%	Community	62.1%
	Relative	6.4%	School	25.6%
	Neighbour	14.3%	Home of neighbour	1.2%
	Boyfriend/girlfriend	23.9%	Other	1.2%
	Other	4.2%	Home of relative	0.2%
	Friends	25.7%		
	Boys	3.6%		
	Girls	1.6%		
	Stranger	16.9%		
Unwanted Sexual touching or kissing	Caregiver	1.1%	Home	13.3%
	Relative	10.3%	Community	49.7%
	Neighbour	11.4%	School	31.8%
	Boyfriend/girlfriend	33.1%	Home of neighbour	2.3%
	Other	9.7%	Other	1.2%
	Friends	16.6%	Home of relative	0.6%
	Boys	5.1%	Perpetrator's home	1.2%
	Girls	1.7%		
Unwanted genital touching	Stranger	1.7%		
	Caregiver	2.9%	Home	19.9%
	Teacher	0.7%	Community	29%
	Relative	14%	School	38.2%
	Neighbour	11.8%	Home of neighbour	1.5%
	Boyfriend/girlfriend	22.8%	Other	1.5%
	Other	11.8%		
	Friends	18.4%		
	Boys	5.9%		
	Girls	2.2%		
Forced sex	Stranger	9.6%		
	Caregiver	1.9%	Home	32.1%
	Relative	23.1%	Community	50.9%
	Neighbour	9.6%	School	11.3%
	Boyfriend/girlfriend	23.1%	Home of neighbour	1.9%
	Other	5.8%	Relative's home	1.9%
	Friends	3.8%	Perpetrator's home	1.9%
	Boys	3.8%		
Forced to watch pornography	Stranger	28.8%		
	Caregiver	1.2%	Home	21%
	Teacher	1.2%	Community	39.5%
	Relative	13.4%	School	37%
	Neighbour	13.4%	Other	2.5%
	Boyfriend/girlfriend	34.1%		
	Other	3.7%		
	Friends	26.8%		
	Boys	1.2%		
	Stranger	4.9%		

3.5.2 What socio-demographic factors put children at higher risk of abuse?

While younger children experience more physical abuse, older children were more likely to report sexual abuse and multiple abuse victimisation. This finding seems broadly in line with literature from other studies in Africa, as shown by a recent systematic review, and from studies in high income countries (Black, Heyman, & Smith Slep, 2001b; Cyr et al., 2013; Meinck, Cluver, Boyes, & Mhlongo, 2014). Age, however, has been shown to interact with ethnicity or severity of abuse in other studies (Black, Heyman, & Smith Slep, 2001a).

Girls were more likely than boys to report emotional and lifetime sexual abuse and were also more likely to report multiple abuse victimisation. These findings correspond to global evidence (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Putnam, 2003). Frequent rape and contact sexual abuse victimisation were equally reported by males and females. However, the number of children reporting contact sexual abuse and rape was too small in this sample to yield robust results. For emotional abuse, only one study in South Africa previously examined gender differences (Thurman & Kidman, 2011). Evidence from other countries is inconclusive thus far regarding gender differences in physical and emotional abuse victimisation (Black, Heyman, et al., 2001a; Black, Smith Slep, & Heyman, 2001).

3.5.3 Who are the perpetrators, and what locations do they use?

Findings show consistent differences between the perpetrators of physical and emotional abuse and of sexual abuse. Whereas the majority of physical abuse was committed by caregivers and teachers within the home and school, emotional abuse was mostly perpetrated by caregivers and other relatives within the home and the child's community. Sexual abuse victimisation was mostly perpetrated by girlfriends/boyfriends or peers and occurred mostly within the community and schools. The majority of rapes were committed by strangers within the community.

Since caregivers are usually the child's main disciplinarian, spend a large amount of time with the child and may consider physical discipline a behaviour measure (Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005), it is not surprising that they are the main perpetrators of physical and emotional abuse (Cicchetti & Carlson, 1989; Garbarino, Guttman, & Seeley, 1986; Glaser, 2002). However, previous evidence suggests that physical punishment remains common in schools across the country despite the abolition of corporal punishment in schools (Morrell, 2001). Our findings are consistent with previous work in this area.

The most common perpetrators of rape were strangers, peers and relatives, which corresponds to findings from other studies in South Africa (Anderson & Ho-Foster, 2008; Jewkes, Levin, Mbananga, & Bradshaw, 2002). Contact sexual abuse and sexual harassment were mostly carried out by peers/friends or relatives, findings which are corroborated by other South African studies (Morrell, 2001). Contrary to other studies carried out in South Africa, few children reported teachers as sexual abusers (Prinsloo, 2006).

3.5.4 Limitations

This study was subject to a number of limitations. First, the prevalence rates of abuse in this sample cannot be generalised across high income areas and other ethnic groups within South Africa. However, the study benefited from in-sample variation such as the inclusion of five language groups and the administering of questionnaires in rural and urban areas in two provinces. Second, data were collected using child self-report only. Evidence suggests that children routinely under-report their experiences of abuse (Gilbert et al., 2009). Studies with parents have shown, however, that parents are even more likely to under-report abusive behaviours towards their children (Johnson et al., 2002). Child self-report is therefore the more suitable measure of abuse for this study. Finally, children were interviewed at home, school or another safe place in the community (e.g., the library). In cases where interviews took place in the home or at school, it is possible that abuse which happened in the interview

location was under-reported. Wherever possible, interviews were carried out in the places requested by participants in order to avoid this situation.

3.5.5 Implications

Current child abuse prevention efforts often focus on younger children, but our results suggest that adolescents are also vulnerable to abuse victimisation (with 34% of the adolescents in this sample experiencing at least one type of frequent abuse victimisation). This suggests a necessary broadening of child protection efforts to include this age group. The findings also demonstrate that despite some differences between boys and girls, and children in rural and urban areas, child abuse appears to be prevalent across genders, locations and settings. Whilst the current child protection system in South Africa mainly focuses on responding to child abuse, policy makers and practitioners should consider investing in child abuse prevention programmes in light of these findings. Programmes such as home-visiting, parent education and multi-component interventions have been shown to be effective in other parts of the world (Mikton & Butchart, 2009). These services could be integrated valuably into family health services such as maternal health, early childhood development, immunisations and adolescent health services (Makoe, Roberts, & Ward, 2012).

3.5.6 Directions for future research

Research investigating risk and protective factors for child abuse victimisation is needed to inform intervention design and programming. Further research is required to examine social and familial predictors of abuse in order to identify modifiable pathways that can be targeted by interventions. Since existing family interventions mostly focus on parents with infants or young children, future research should consider the design and evaluation of child abuse prevention interventions for families with older children and adolescents. Furthermore, the

role that gender might play (for both the child and the perpetrator) in sexual abuse victimisation needs to be investigated.

Future research could also investigate risk factors for multiple abuse victimisation in South Africa. Child abuse prevention efforts should consider the importance of co-occurrence of several types of abuse, since studies have shown that multiple childhood abuse victims are at a higher risk of developing trauma symptomology and are more likely to experience severe abuse (Clemmons, Walsh, DiLillo, & Messman-Moore, 2007; Vranceanu, Hobfoll, & Johnsonc, 2007).

3.5.7 Conclusion

Incidence and prevalence rates of physical, emotional and sexual abuse in South Africa are high in comparison to Western samples and comparable to rates shown in other sub-Saharan African countries. Many children also report multiple abuse victimisation. Perpetrators of physical abuse are mainly caregivers and teachers. Perpetrators of emotional abuse tend to be caregivers and relatives. Sexual abuse is perpetrated mainly by intimate partners and peers.

The findings of this study have implications for the design of policy and programming in South Africa. Policy makers could invest in evidence-based child abuse prevention interventions which are culturally and contextually acceptable. These interventions could be integrated into the services currently available to families.

3.6 References

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4 - Paper #3: Household illness, poverty, disability, and physical and emotional child abuse: Findings from South Africa's first prospective study

Under review: Journal of Interpersonal Violence



Picture: Community meeting, rural area in Mpumalanga

This paper addresses the study questions on risk factors for physical and emotional child abuse victimisation in South Africa (research questions 5 and 6). It investigates the effect of household chronic illnesses on physical and emotional abuse as identified in the systematic review (Paper 1), and whether the relationship between illness and abuse could be mediated by other factors. The introduction provides contextual evidence and background information. The paper then details the aims, the methods and measures used for data collection, and the analytical approach. It describes the results found in three additional sections. Section one explains the socio-demographic characteristics of the participants (n=3401) and the differences between healthy, AIDS-affected and other chronically ill households. Section two illustrates the differences between children lost at follow-up and those retained. Section three explains the results of the multiple mediation analysis. Poverty and disability were found to be strong correlates of

physical and emotional abuse victimisation by the systematic review (Paper 1), and it was therefore hypothesised that they would mediate the relationship between household illness and these kinds of abuse. Results are then discussed in the context of international research together with implications for future research, policy and practice.

Which research questions does this paper answer?

5. Are there any direct effects of household illness (AIDS and other) on physical and emotional child abuse?

6. Is the relationship between household illness and abuse mediated by the extent of the ill person's disability or by poverty?

Abstract

This study examines the relationship between baseline household chronic illness (AIDS or other-illness) and physical and emotional abuse victimisation in a random community-based sample of children aged 10-17 (n=3515, 56.7% female) in rural and urban areas in South Africa. Anonymous self-report questionnaires using internationally utilised scales were completed at baseline and a year later at follow-up (96.8% retention rate). Using multiple mediation analyses, this study investigated direct and indirect effects of chronic household illness on frequent (monthly) physical and emotional abuse victimisation, with poverty and extent of the ill person's disability as hypothesised mediators. For boys, a direct effect of household AIDS-illness on physical and emotional abuse and an indirect effect through poverty were detected. In addition, indirect effects of other chronic illnesses on physical and emotional abuse through poverty and disability were found. For girls, an indirect effect of household AIDS-illness on emotional abuse through poverty was observed. In addition, an indirect effect of other chronic illnesses on emotional abuse through poverty and an indirect effect of other chronic illnesses on physical abuse through disability were found. These results indicate that children in families affected by AIDS and other chronic illnesses are at higher risk for child abuse victimisation. For AIDS-affected children, this risk is mediated by higher levels of poverty; for children affected by other chronic illnesses, this risk is mediated by higher levels of household disability. Interventions aimed at reducing poverty and increasing family support may help prevent child abuse in families experiencing chronic illness in South Africa.

Keywords: child abuse, adolescent abuse, HIV/AIDS, predictors, risk factor, chronic illness

4.1 Background

Approximately 40 million children under 14 years of age are victims of abuse and neglect worldwide (World Health Organization, 2006), with children in the sub-Saharan African region suffering from particularly high rates of abuse (Akmatov, 2011; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Explanations for these elevated prevalence rates in Africa often lack empirical basis. Poorly developed child protective systems, modernisation and negation of traditional values, large numbers of orphaned children, and disruption of community structures and social norms are some hypothesised causes (Lachman et al., 2002).

Like other countries in the region, South Africa also experiences a considerable burden of disease, with large numbers of people suffering from communicable (e.g., HIV and TB) and non-communicable illnesses (e.g., high blood pressure and diabetes) (Wyk et al., 2013). Research has shown that violence and poor health are correlated, especially in low- and middle-income countries in Africa (World Health Organization, 2009), and a recent systematic review of correlates of child abuse victimisation in Africa found an association between household illness and child abuse (Meinck, Cluver, Boyes, & Mhlongo, 2014). It is unclear, however, whether the cross-sectional relationship between household illness and child abuse is sustained over time using longitudinal data. Thus far, no research has examined whether households with certain types of chronic illnesses such as AIDS differ in their risk for physical and emotional child abuse victimisation. There may be specific direct and indirect pathways from household chronic illnesses to parenting challenges in the home.

In order to understand the relationship between household illness and child abuse, it can be valuable to situate household illness within a larger ecological model (Belsky, 1993). This framework places the child at the centre of multiple interacting spheres of influence such as peers, family, community and society. While there may be a direct effect of household illness

on child abuse, an indirect effect of household illness on risk for child abuse victimisation through additional factors (e.g., stress, pain, fatigue or stigma) is probable (Belsky, 1980).

Indirect effects of household illness on risk for child abuse victimisation are investigated using mediators. Mediating factors are variables that play an important role in governing the relationship between the hypothesised risk factor and the outcome. As chronic illnesses can affect patients differently and manifest in different ways, some aspects of suffering from a chronic illness may be particularly prone to affect the risk for child abuse victimisation (i.e., poor mental health) while others are not. Mediation analysis can be used to examine how these particular aspects influence the relationship between chronic illness and child abuse. Whether or not there is a direct link between chronic illness and child abuse victimisation, it is possible that chronic illness exacerbates other factors, which in turn increase the risk for child abuse.

A recent systematic review identified household poverty and disability as common correlates of physical and emotional child abuse victimisation (Meinck et al., 2014). International research has found a strong circular link between poverty and ill health (Bonds, Dobson, & Keenan, 2012; Grant, 2005) and poverty and child abuse (Stith et al., 2009). A trial of an intervention carried out in Wisconsin with families affected by poverty showed that families who received financial aid had lower levels of contact with child protective services compared to those who did not (Cancian, Shook Slak, & Yang, 2010). Previous studies in South Africa have found that children in AIDS-affected families report consistently higher levels of poverty than children in healthy families or those affected by other illnesses (Cluver et al., 2013; Foster & Williamson, 2000). Studies from the United Kingdom suggest that parents with disabilities are more likely to live in low-income households and to be economically inactive (Disability Rights Commission, 2006). In addition, parents or caregivers with disabilities may be at a greater financial disadvantage because they have to pay for additional support concerning daily chores and while parenting (Preston, 2005).

Studies from the United States found that mothers with chronic pain reported more lax parenting and poorer relationships with their children (Evans, Shipton, & Keenan, 2006). They experienced more psycho-social distress which had an impact on their parenting, their ability to parent positively in particular (Evans & de Souza, 2008; Evans, Shipton, & Keenan, 2005). Likewise, paternal illness predicted negative family functioning (Steele, Forehand, & Armistead, 1997). The greater the number of stress factors (e.g., ill health, physical problems and poverty) a parent experienced, the less likely they were to cope with parenting (Ghate & Hazel, 2008).

However, existing evidence is thus far unclear about the ways in which household illness, poverty, and disability link together with child abuse victimisation. A previous study from South Africa found that poverty, extent of the ill person's disability and abuse were all interlinked pathways between having an AIDS-ill caregiver and negative child outcomes (Cluver et al., 2013). Evidence suggests that families affected by AIDS appear to be at particular risk for child abuse (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011). It is unclear, however, whether children in families affected by AIDS or other chronic illnesses are at equal risk for abuse victimisation and what the mechanisms of these relationships are.

To date, understanding of risk factors for child abuse in South Africa has been limited in a variety of ways. First, all of the studies are cross-sectional in design, limiting our ability to determine direction of association (Meinck et al., 2014; Murray, Farrington, & Eisner, 2009). Second, the majority of studies used retrospective recollections of childhood abuse (Breiding et al., 2011; Jewkes, Levin, Mbananga, & Bradshaw, 2002), which may be subject to recall bias (Hardt & Rutter, 2004). Third, samples mostly consist of high school and university students (Anderson & Ho-Foster, 2008; Collings, 1991), which may exclude some of the most vulnerable children who may not be attending school (Meinck, Cluver, Boyes, & Ndhlovu, 2013). Fourth, some studies use patient chart data from mental health units, court records and

social services (Carey, Walker, Roussow, Seedat, & Stein, 2008; Collings, 1993), which are subject to bias as only the most severe or identifiable cases may have been reported to officials (Finkelhor, 1993). Fifth, no published study has examined the way in which risk factors interact with each other.

Therefore, the current study had two aims. First, we aimed to determine the direct and indirect effects of baseline household *AIDS-illness* on physical and emotional child abuse victimisation at follow-up. Second, we aimed to examine direct and indirect effects of baseline *household other chronic illness* on physical and emotional child abuse victimisation at follow-up (Figure 4-1). All analyses were disaggregated by child gender.

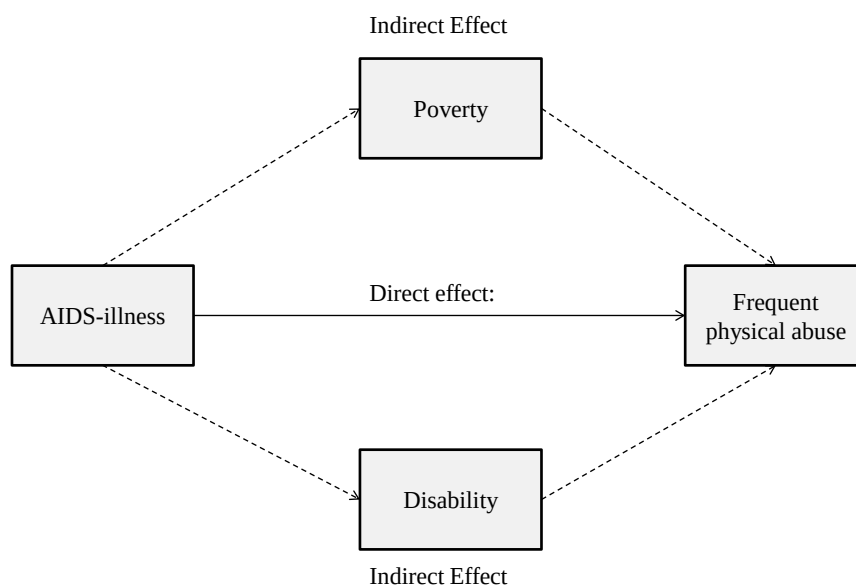


Figure 4-1: Hypothesised direct effect and partial indirect effects of household chronic illness on physical and emotional abuse

4.2 Methods

4.2.1 Participants

Participants: 3515 children aged 10-17 (mean age 13.5 years, 56.7% female, 50.6% urban location) were originally recruited between January 2010 and June 2011 in four health districts

with >30% HIV prevalence in rural and urban areas of Mpumalanga and the Western Cape. Within each health district, census enumeration areas were randomly selected. All households with children aged 10-17 within each census enumeration area were included in the study. One child in each household was interviewed, and where there were multiple children in the household, one was chosen at random. Between January 2011 and June 2012, 3401 participants (96.8% retention rate) were traced and re-interviewed. Refusal rate was 2.8% at baseline and <0.5% at follow-up.

4.2.2 Procedure

Procedure: Children completed an anonymous interviewer-guided 60-minute self-report questionnaire that had been translated into Xhosa, Swati, Tsonga, Sepedi and Zulu and checked by back-translation. Interviews were carried out in locations selected by the child in order to guarantee confidentiality and privacy (e.g., under a secluded tree, in an empty classroom). Interviewers received intensive training in working with vulnerable children and administering standardised questionnaires. Participation was voluntary, and children were able to stop the interview at any time. All participants received a certificate and light refreshments irrespective of whether they completed the questionnaire. Due to low literacy in the sampled population group, information and consent sheets were read out loud to children and caregivers, and clarification questions were answered until participants were satisfied and consented to take part. Stringent quality checks were in place so that missing data were <0.5%. All survey items were pre-piloted with vulnerable youth to investigate age appropriateness and cultural sensitivity. Ethical approval was granted by the Universities of Oxford, KwaZulu-Natal and Cape Town as well as the Provincial Departments of Health and Education and the National Department of Social Development.

Confidentiality was maintained throughout the study unless participants were considered to be at risk of significant harm or if they had requested help, provisions clearly outlined in the

consent forms. Where this was the case, the project manager and interviewer discussed referral options with the child. Following discussion with the participants, immediate referrals were made to local child protection services for children experiencing ongoing severe physical, emotional or sexual abuse. Where children had experienced abuse in the past, referrals to counselling centres and HIV-testing services were made where requested, and if appropriate. In total, 664 referrals were made.

4.2.3 Measures

All measures of abuse were pre-piloted and modified to fit cultural contexts with the help of experienced social workers, child protection NGOs and vulnerable children in South Africa. The whole abuse scale showed good reliability in this sample ($\alpha = .73$). *Child physical and emotional abuse victimisation* at follow-up were measured using seven items from the UNICEF Measures for National-Level Monitoring of Orphans and other Vulnerable Children (Snider & Dawes, 2006), which are based on the Conflict Tactic Scales for Parent and Child (CTSPC) (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). To date, the CTSPC has been used in international studies around the world (Leung, Wong, Chen, & Tang, 2008; UNICEF, 2010). The UNICEF measure has not been validated in South Africa but was used successfully in another study in the Western Cape and showed good reliability ($\alpha = .70$) (Meinck et al., 2013). Seven additional items were devised through qualitative pre-piloting with practitioners and vulnerable children ($\alpha = .74$ for all 14 items on this sub-scale). Past-year frequency of abuse was measured (0: *never*; 1: *not in the last year*, 2: *at least once this year*; 3: *month*; 4: *weekly*). A conservative threshold for frequent abuse was set as occurrence of physical or emotional abuse on a monthly or more frequent basis within the last year (Table 4-1). A dichotomous variable was created for physical and emotional abuse (0: *no monthly abuse*; 1: *yes monthly abuse*).

Household chronic illness and extent of disability were measured using a Verbal Autopsy Checklist (Lopman et al., 2006) that included symptoms of AIDS-related illness (i.e., HIV-

wasting syndrome, Kaposi's sarcoma and oral candidiasis) and symptoms of other chronic illnesses common in South Africa, such as diabetes, high blood pressure, arthritis, emotional problems and cancer (Health Systems Trust, 2006). The Verbal Autopsy has been validated in South Africa (Hosegood, Vanneste, & Timaeus, 2004) and was applied to all household members who had been ill for a period of at least two weeks. Determination of household AIDS-illness required identification of three or more AIDS-defining symptoms. Dichotomous variables were created for household AIDS-illness (*0: not ill with AIDS; 1: ill with AIDS*) and other chronic illnesses (*0: not ill with other chronic illness; 1: ill with other chronic illness*). Extent of the ill person's disability was measured using seven items from the WHO International Classification of Functioning, Disability and Health 'activity limitation and participation' sub-scale (World Health Organization, 2003). Example items include difficulty of carrying shopping or carrying out personal hygiene, and responses are rated according to level of difficulty (*0: not at all difficult; 1: a little difficult; 2: very difficult; 3: not able to do it*). Items were summed to give a total disability score. The scale showed good reliability in this sample $\alpha = .93$.

Household poverty was measured using an index of access to the eight highest socially-perceived necessities for children in South Africa (Barnes & Wright, 2012), which showed good reliability of $\alpha = .80$ in this sample. Necessities included having enough clothes to remain warm and dry, soap to wash every day, three meals per day, doctor's visits, medicines when needed, school uniform, money for school fees and more than one pair of shoes. Items were reverse scored (*0: has access to item; 1: does not have access to item*) and summed to give a total poverty score (i.e., total number of necessities lacking).

Demographic covariates of gender, age, formal/informal housing and urban/rural location were measured using items modelled on the South African Census (Statistics SA, 2001).

Table 4-1: Questionnaire items for Child physical and emotional abuse victimization

Questionnaire items:	Source:
Physical Abuse	
<i>How often in the past year did an adult...</i>	
1) use a stick, belt or other hard item to hit you?	UNICEF Measures
2) slap, punch or hit you so that it hurt?	UNICEF Measures
3) make you stand or kneel in an uncomfortable position for a long period of time to punish you?	Items design by local social workers, NGO staff, and children from the local community.
Emotional Abuse	
<i>How often in the past year did an adult...</i>	
4) threaten to send you away or kick you out of the house?	UNICEF Measures
5) threaten to invoke ghosts or evil spirits or harmful people?	UNICEF Measures
6) call you dumb, lazy or other names?	UNICEF Measures
7) withhold a meal to punish you?	UNICEF Measures
8) single you out to do household chores all day instead of school or play?	UNICEF Measures
9) threaten to hurt you or give you bad grades?	Items design by local social workers etc.
10) insult members of your family that have passed away?	Items design by local social workers etc.
11) tell you they wished they did not have to look after you or make you feel you are a burden	Item designed by local social workers etc.
12) threaten to leave you and never come back?	Items design by local social workers etc.
13) make you feel unwelcome at home?	Items design by local social workers etc.
14) threaten to hurt or kill a person or an animal that you care about?	Items design by local social workers etc.

4.3 Analysis:

Analyses were conducted in three stages, using SPSS 20. First, differences in socio-demographic characteristics and physical and emotional abuse victimisation between children lost (n=114) and retained (n=3401) at follow-up were investigated. Second, descriptive analyses investigating relationships between gender, illness-status, disability and poverty were carried out. Third, multiple mediation tests were conducted separately for boys and girls to determine direct and indirect effects of chronic household illnesses on child abuse victimisation. Other than Baron & Kenny (1986), Hayes (2009) and Zhao, Lynch & Chen (2010) do not impose the necessity that two variables have to be associated with each other in order to test hypothesis of indirect effects.

Multiple mediation analyses used Preacher and Hayes's (2004) bootstrapping procedure. This is a non-parametric sampling procedure recommended for simultaneous testing for indirect effects of multiple mediators. It allows determination of the extent to which each mediator variable affects the relationship between the hypothesised predictor and the outcome in the presence of other potential mediators. Tests for significant mediation required bias-corrected 95% confidence intervals to not overlap zero, based on 1000 bootstrap samples (Preacher & Hayes, 2008). All mediational analyses adjusted for age, rural/urban location, informal housing and province.

4.4 Results

Socio-demographic statistics for the population sample are summarised in Table 4-2. The sample included 1095 participants from AIDS-ill households (31.2%) and 482 participants from households with other chronic illnesses (13.7%) at baseline. Girls experienced higher rates of emotional abuse ($\chi^2 = 8.591$; $p = 0.003$), and more girls lived in AIDS-ill households ($\chi^2 = 11.061$; $p = 0.004$) (Table 4-3). Households affected by AIDS experienced higher levels of

poverty and disability compared to those with other chronic illnesses (Table 4-4). For relationships between all the variables in the models, please see the correlation table at the end of the paper (Table 4-5). Prevalence rates in this study were 16.6% for frequent physical abuse and 20.7% for frequent emotional abuse victimisation.

Table 4-2: Characteristics of the sample at baseline and follow-up

	Baseline (n=3515)	Follow-up (n=3401)
Gender (female)	56.7% (1992)	56.4% (1919)
Rural Area	49.4% (1737)	49.4% (1681)
Mpumalanga Province	47.3% (1664)	49.8% (1681)
Informal Housing	31.8% (1117)	20.6% (701)
Mean age	13.45 years (SD 2.15) SE .036	14.67 years (SD 2.22) SE .038
Poverty	2.71 (SD 2.32) SE .040	2.75 (SD 2.34) SE .040
Frequent Physical Abuse	18.3% (645)	16.6% (564)
Frequent Emotional Abuse	19.5% (687)	20.7% (704)
AIDS-Illness	31.2% (1095)	17.7% (602)
Other Chronic Illness	13.7% (482)	12.5% (424)
Extent of ill person's disability	2.08 (SD 3.87) SE .065	1.18 (SD 3.08) SE .053

4.4.1 Children lost and retained at follow-up

Children lost to follow-up did not differ from those retained with regard to gender ($\chi^2 = 0.07$; $p = 0.789$) or frequent physical abuse ($\chi^2 = 1.562$; $p = 0.211$). However, children lost at follow-up were more likely to have experienced frequent emotional abuse ($\chi^2 = 6.624$; $p = 0.010$), were older ($t = 6.44$; $p = 0.011$) and lived in poorer households ($t = 21.55$; $p < 0.001$) than children retained at follow-up. Therefore, it is possible that more vulnerable children were lost to follow-up, and findings should be interpreted with this in mind.

Table 4-3: Gender differences in the variables used for analysis

	Boys (n=1482)	Girls (n=1919)
Rural Area	42.4% (712)	57.6% (969)
Mpumalanga Province	45.3% (746)	54.7% (902)*
Informal Housing	41.6% (444)	58.4% (624)
Mean age	13.41 (SD 2.10) SE .055	13.44 (SD 2.18) SE .050*
Poverty	2.61 (SD 2.30) SE .060	2.74 (SD 2.33) SE .053
Frequent Physical Abuse at follow-up	44.5% (251)	55.5% (313)
Frequent Emotional Abuse at follow-up	38.5% (271)	61.5% (433)**
AIDS-illness	39.2% (417)	60.8% (646)***
Other Chronic Illness	46.3% (219)	53.7% (254)
Extent of ill person's disability	1.97 (SD 3.87) SE .101	2.14 (SD 3.80) SE .087

χ^2 and two-sample *t*-tests Note: * $p < .05$, ** $p < .01$, *** $p < .001$

4.4.2 Mediation analysis

Meditational analyses were conducted for both household AIDS-illness and other chronic illness in line with Hayes (2009) to establish the extent of mediation. Eight separate models tested the direct and indirect effects of household AIDS-illness and other chronic illnesses on child abuse through poverty and the extent of the ill person's disability. Models were run separately for boys and girls. All analyses controlled for age, rural location, informal housing and province.

Table 4-4: Characteristics of the outcome and mediator variables split by household illness status

	Healthy	Other chronic illness	AIDS-III
Physical Abuse	14.9% (278)	11.3% (64)	20.9% (222)***
Emotional Abuse	18.7% (349)	19.9% (94)	24.6% (261)***
Poverty	2.58 (SD 2.29) SE .05	2.06 (SD 2.02) SE .93	3.14 (SD 2.39) SE .07***
Disability	.36 (SD 1.76) SE .04***	2.81 (SD 3.87) SE .18	4.74 (SD 4.73) SE .15***

χ^2 and two-sample *t*-tests Note: * $p < .05$, ** $p < .01$, *** $p < .001$

4.4.3 Frequent physical abuse victimisation

For boys (Figure 4-2), a direct effect of household AIDS-illness on frequent physical abuse victimisation was observed ($B = 0.334$, 95% CI 0.006 - 0.663). Additionally, an indirect effect

through poverty was observed ($B = 0.080$, 95% CI 0.029 - 0.142). Disability did not affect the relationship between AIDS-illness and physical abuse victimisation.

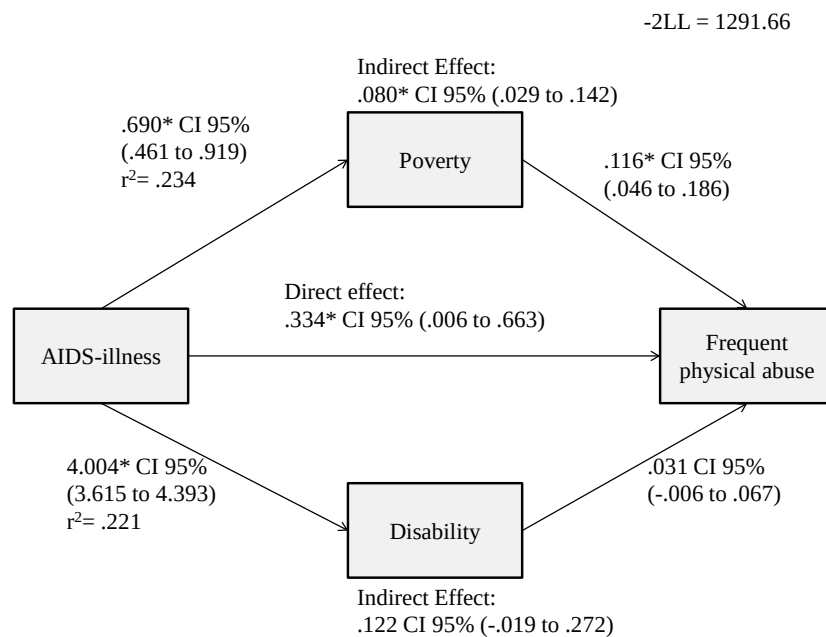


Figure 4-2: Final multiple mediation model examining the direct and indirect effects of household AIDS-illness on physical abuse in boys

There was no direct effect of other chronic illness on frequent physical abuse. However, an indirect effect of other chronic illness on frequent physical abuse through poverty ($B = -0.045$, 95% CI -.100 – 0.009) and disability ($B = 0.051$, 95% CI 0.019 – 0.108) was also observed for boys (Figure 4-3).

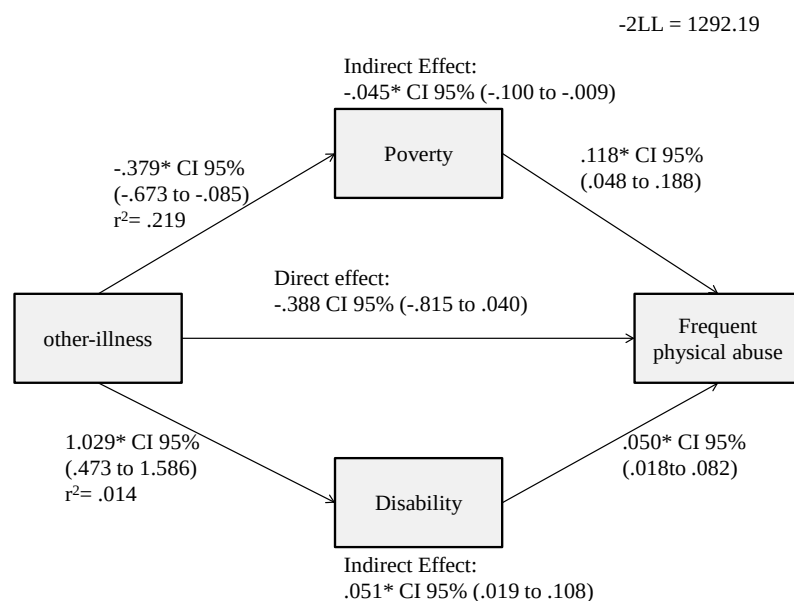


Figure 4-3: Final multiple mediation model examining the direct and indirect effects of household other-illness on physical abuse in boys

For girls (Figure 4-4), no direct effect of household AIDS-illness on frequent physical abuse victimisation was observed. In addition, no indirect effect of AIDS-illness on frequent physical abuse victimisation through poverty or disability was observed.

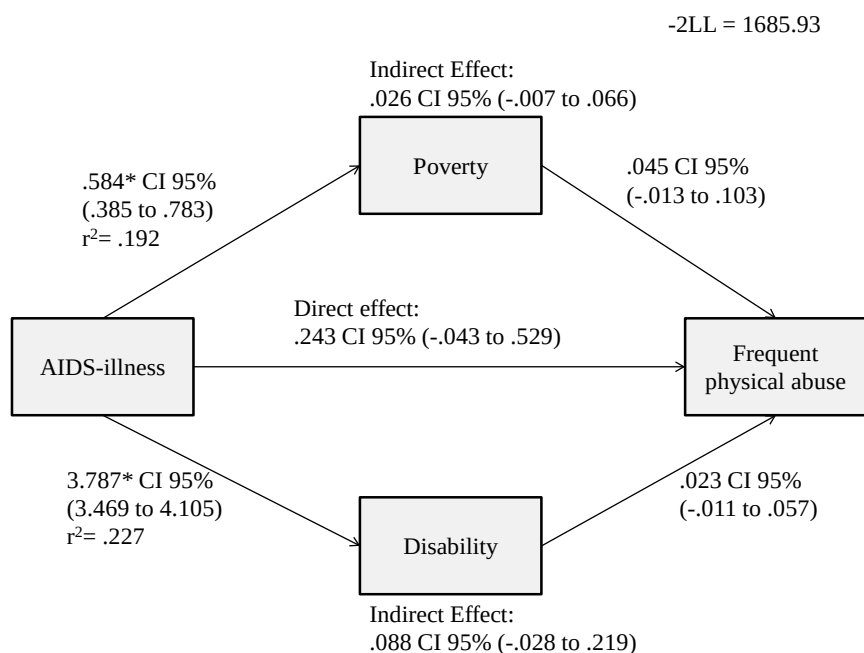


Figure 4-4: Final multiple mediation model examining the direct and indirect effects of household AIDS-illness on physical abuse in girl

There was no direct effect of other chronic illness on frequent physical abuse. However, there was an indirect effect of household other chronic illness on frequent physical abuse victimisation through disability ($B = 0.031$, 95% CI 0.008 - 0.075) (Figure 4-5).

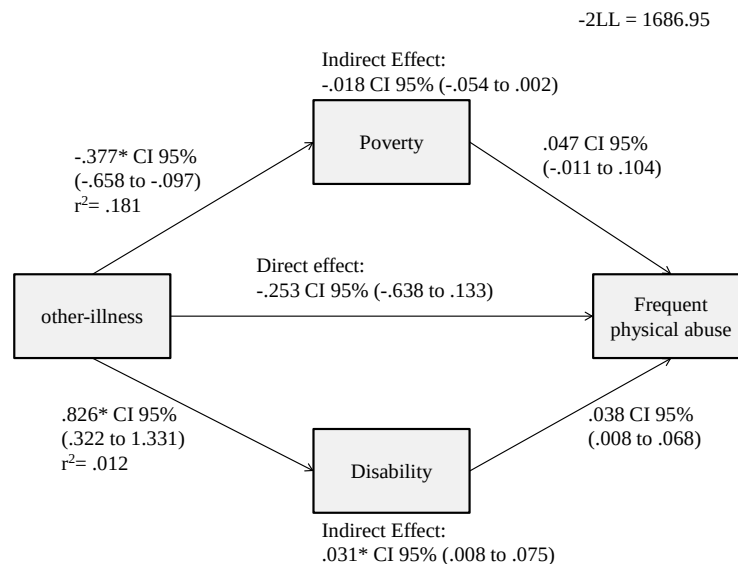


Figure 4-5: Final multiple mediation model examining the direct and indirect effects of household other-illness on physical abuse in girls

4.4.4 Frequent emotional abuse victimisation

For boys (Figure 4-6), a direct effect of household AIDS-illness on frequent emotional abuse victimisation was observed ($B = 0.409$, 95% CI 0.088 - 0.729). Additionally, an indirect effect of household AIDS-illness on frequent emotional abuse through poverty was obtained ($B = 0.091$, 95% CI 0.044 - 0.157). Disability did not affect the relationship between AIDS-illness and frequent emotional abuse.

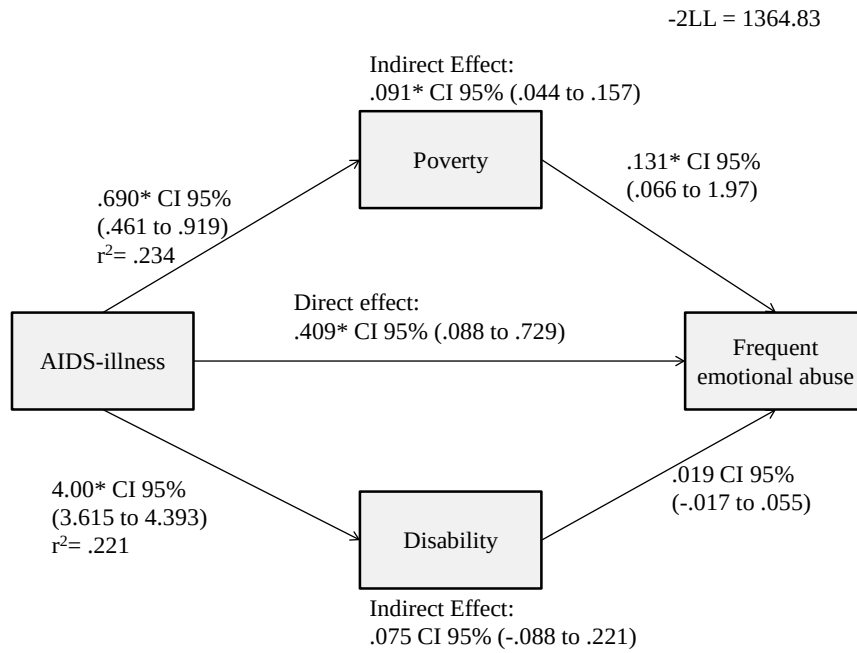


Figure 4-6: Final multiple mediation model the direct and indirect effects of household AIDS-illness on emotional abuse in boys

There was no direct effect of other chronic illness on frequent emotional abuse. However, an indirect effect of other chronic illness on frequent emotional abuse through poverty ($B = -0.052$, 95% CI -0.112 - -0.015) and disability ($B = 0.042$, 95% CI 0.010 to 0.096) was observed (Figure 4-7).

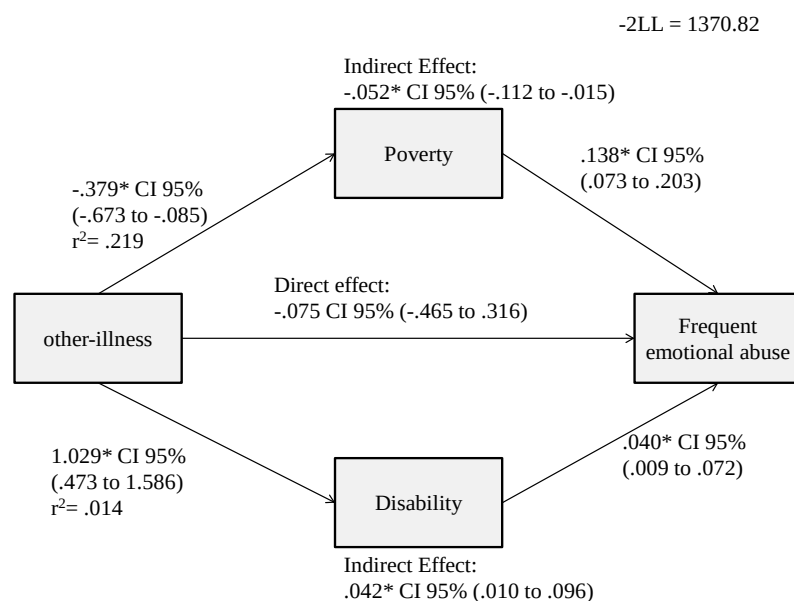


Figure 4-7: Final multiple mediation model examining the direct and indirect effects of household other-illness on emotional abuse in boys

For girls (Figure 4-8), an indirect effect between household AIDS-illness and frequent emotional abuse victimisation through poverty ($B = 0.054$, 95% CI 0.024 - 0.093) was observed. Disability did not affect the relationship between AIDS-illness and frequent emotional abuse.

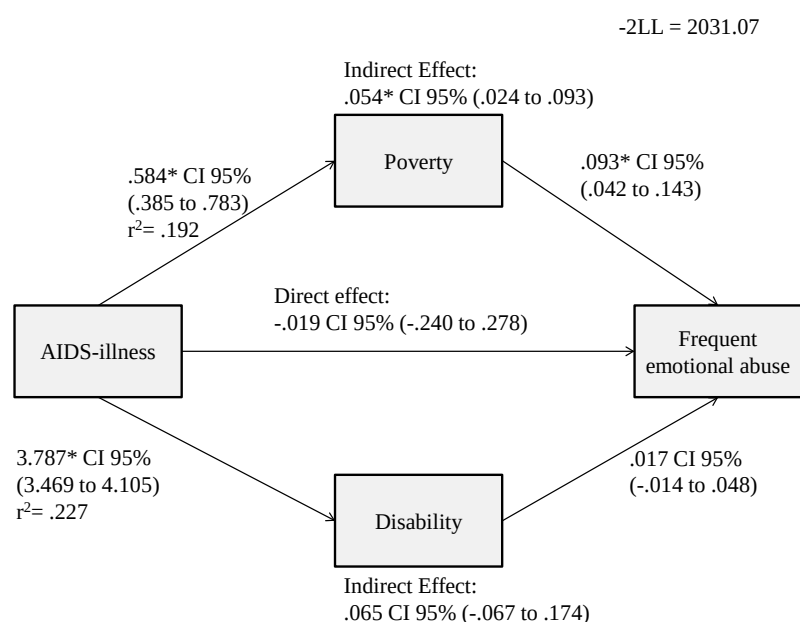


Figure 4-8: Final multiple mediation model examining the direct and indirect effects of household AIDS-illness on emotional abuse in girls

There was no direct effect of other chronic illness on frequent emotional abuse. However, an indirect effect of other chronic illness and frequent emotional abuse through poverty ($B = -0.035$, 95% CI -0.072 - -0.011) was observed (Figure 4-9).

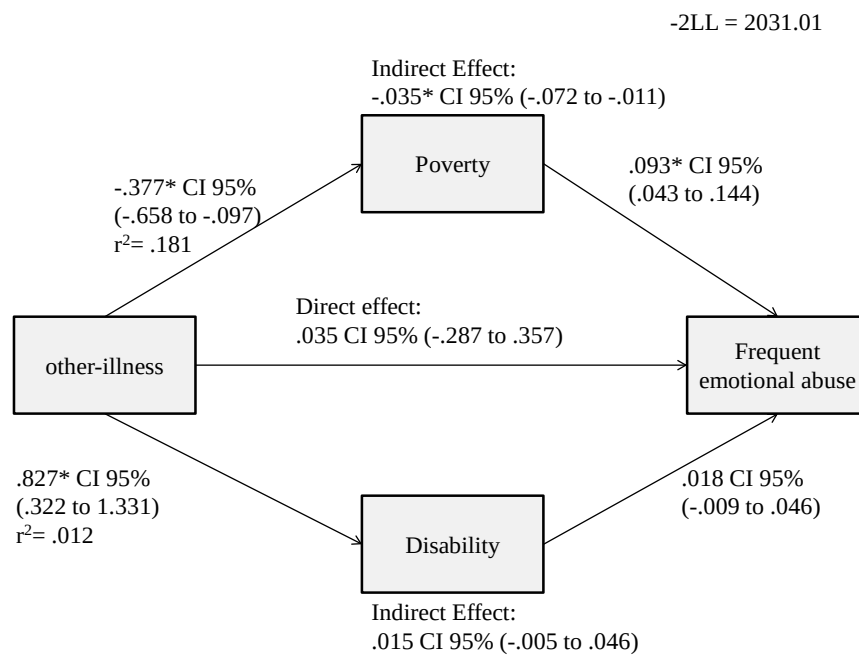


Figure 4-9: Final multiple mediation model examining the direct and indirect effects of household other-illness on emotional abuse in girls

4.5 Discussion

This is the first large-scale longitudinal study examining the relationships between household chronic illness and child abuse in the developing world through multiple mediation analysis. Direct and indirect effects of household chronic illness on physical and emotional abuse victimisation were found. In particular, direct and indirect effects were observed for household AIDS-illness while indirect effects were observed for household other chronic illness. These findings correspond with previous research from South Africa, which found direct associations

between physical and emotional abuse victimisation and household AIDS-illness but not with other chronic illnesses (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Meinck, Cluver, Boyes, & Ndhlovu, 2013).

As hypothesised, poverty was an important mediator of the relationship between AIDS-illness and physical and emotional abuse. Unexpectedly, poverty was a protective mediator of the relationship between other chronic illness and physical and emotional abuse. This study thus corroborates current evidence that found that households affected by other chronic illness in South Africa appear to be at lower risk of poverty than those affected by AIDS (Cluver & Orkin, 2009). The much lower risk for poverty in households affected by other chronic illness decreased the risk for child abuse victimisation in the mediation models. However, poverty as a factor itself remained clearly linked to an increased risk of child abuse.

Differences in poverty risk between households affected by AIDS and other chronic illness could be attributed to differences in the age groups between the ill household members. Chronic illnesses measured in this study (i.e., high blood pressure, diabetes) may be more likely to appear in older people, who are entitled to a state pension in South Africa (Gómez-Olivé, Thorogood, Clark, Kahn, & Tollman, 2013). Of the children in households with chronic illnesses in this study, 26.6% reported being cared for by their grandparents, compared to 13.8% in AIDS-affected households. State pensions have been shown to reduce household poverty as they are spread across all members of a household (Barrientos et al., 2003; Legido-Quigley, 2003).

The role of poverty is consistent with research linking AIDS-affected households with high levels of deprivation (Gilborn, Nyonyintono, Kambumbuli, & Jagwe-Wadda, 2001) as AIDS-illness increases household poverty (Piot, Greener, & Russel, 2007) through inability to work, medical expenses and excessive funeral costs in case of AIDS-death (Collins & Leibbrandt,

2007). In addition, poorer households are at higher risk for HIV infection and this can set up a vicious cycle (Whiteside, 2002).

There are a number of routes by which poverty may increase risk of abuse. Previous research suggests that economic status and social support are highly correlated with caregiver depression (Kagotho & Ssewamala, 2012), which is further exacerbated by food insecurity (Kuo, Operario, & Cluver, 2012). Poverty and poor physical health also predict increased psychological stress in kinship carers (Kelley, Whitley, Sipe, & Crofts Yorker, 2000). In settings with high HIV-prevalence, high levels of stress, depression and poor physical health were found amongst adults caring for children (Kuo & Operario, 2011). A previous study from South Africa found that household AIDS-illness was associated with reduced capacity for positive parenting (Lachman, Cluver, Boyes, Kuo, & Casale, 2013). Research from high-income countries also shows poorer parent-child relationships and more inconsistent parenting amongst HIV-positive parents and those suffering from chronic pain (Armistead & Forehand, 1995; Evans, Shipton, & Keenan, 2006; Steele, Forehand, & Armistead, 1997).

While disability was not a mediator of the relationship between household AIDS-illness and child abuse, disability mediated the relationship between other chronic illness and physical and emotional abuse. The role of disability as a mediator is consistent with research linking poor caregiver health to higher risk of abuse (Steele et al., 1997). There are a number of ways in which disability may increase risk of abuse. Previous research suggests that physical disability in chronically ill patients is highly correlated with poor mental health (Cassileth et al., 1984). Larger numbers of symptoms and a higher extent of disability were found to be associated with higher parental distress and aggravation during parenting tasks (Annunziato, Rakotomihamina, & Rubacka, 2007). Furthermore, illness-related demands predicted lower parenting quality, which in turn predicted child behaviour problems (Lewis & Hammond, 1996). Household illness and high levels of disability, coupled with stigma and poverty, may therefore lead to

increased stress, poorer parenting and mental health, which can increase child conduct problems, all of which have been found to be risk factors for child abuse (Stith et al., 2009). Future research should investigate the relationships between child abuse and caregiver/household illness and caregiver mental health.

4.5.1 Limitations and Future Research

This study had a number of limitations. First, less than two-thirds of the South African population know their HIV status, which makes self-reporting of HIV status unreliable (Peltzer, Matseke, Mzolo, & Majaja, 2009). As a result, this study was unable to identify households with asymptomatic HIV-positive members. However, the Verbal Autopsy to identify AIDS-illness has been used successfully in previous studies with good reliability (Boyes, Mason, & Cluver, 2013; Cluver, Bowes, & Gardner, 2010; Cluver et al., 2013; Meinck et al., 2013). Furthermore, identifying only households with AIDS sequelae allows for a fuller understanding of this sub-group of individuals. Second, no scales for child abuse victimisation have been validated for use in South Africa. However, all scales were used successfully in prior studies and showed good reliability in this sample (Cluver, Kganagka, & Kuo, 2010; Cluver & Orkin, 2009; Meinck et al., 2013).

Third, the study was carried out in randomly-sampled areas with >30% HIV-prevalence. Results cannot, therefore, be generalised across the child population of South Africa, but they give a good indication of risks for children in low-income areas with high HIV-prevalence. Fourth, this study measured the risk of abuse in families affected by chronic illness; however, it should be noted that the ill person and the person abusing the child may not be the same individual. However, the results clearly indicate that household illness increases the risk for child abuse victimisation through poverty and extent of disability. Fifth, there is a strong likelihood of unmeasured confounding in this study, as suggested by the low values in R^2 . Even though models adjusted for potential confounding variables reported by children, we were

unable to account for caregiver-related confounders such as mental health or substance use. Due to the design of the study, unmeasured confounding cannot be ruled out.

Finally, the study used child self-report with interviewer-guided questionnaires. Opinions differ whether children are reliable informants regarding disability and illness within the household. However, previous research using the Verbal Autopsy and disability measures have been successful (Cluver et al., 2013), and research has shown that children often carry out caring tasks within the home, which allows them to witness physical ability and symptomology of ill household members (Lane, 2012). Interviewer presence during the survey may have increased the likelihood of under-reporting, of socially undesirable events such as child abuse in particular. Computer-assisted interviewing may increase reporting of stigmatised events or behaviours in some cases (Richens et al., 2010); however, it may not be suitable for all settings, such as the very rural ones in which parts of this study were conducted, where participants may be intimidated by using computers to answer questions (Mensch, Hewett, Gregory, & Helleringer, 2008; Potdar & Koenig, 2005). The advantage of the system used in this study is that it allowed for more detailed answers and helped to develop good interviewer-participant relationships, which facilitated follow-up. Future work is needed to examine other potential factors, such as parental risk factors of mental health and substance abuse (Black, Heyman, & Smith Slep, 2001a, 2001b; Stith et al., 2009; Walsh, MacMillan, & Jamieson, 2003), as well as predictors of multiple abuse victimisation.

4.5.2 Applicability/Implementation

There are currently an estimated 85 million AIDS-affected children in sub-Saharan Africa (UNICEF, 2013), and millions more children live in households affected by chronic illness (Shisana et al., 2013). The present study shows that children in households with chronic illness experience higher risk of physical and emotional abuse, in part due to higher levels of poverty and disability. This finding suggests the importance of services recognising children affected

by chronic illness and AIDS as a group at heightened risk of abuse and incorporating this reality into assessments of child well-being. In particular, interventions that effectively lower household poverty levels and support families with chronic illnesses may have additional positive impacts on reducing risks of child abuse. To reduce the compound vulnerability of children in households affected by chronic illness and to address child abuse in South Africa, it is essential that we test child abuse interventions rigorously and take those which are effective to scale.

Table 4-5: Correlation matrix of all variables in the models

	AIDS-ill	Other ill	Healthy	Disability	Poverty	Physical Abuse	Emotional Abuse	Age	Gender	Urban/ Rural	Province	Informal Housing
AIDS-ill	1.000											
Other –ill	-.271***	1.000										
Healthy	-.743***	-.443***	1.000									
Disability	.471***	.078***	-.493***	1.000								
Poverty	.134***	-.108***	-.050***	.127***	1.000							
Physical Abuse	.078***	-.033	-.050***	.071***	.054***	1.000						
Emotional Abuse	.064***	-.008	-.054***	.062***	.102***	.381***	1.000					
Age	.022	-.013	-.011	.029	.018	-.064***	.024	1.000				
Gender	.056***	-.024	-.036*	.022	.028	-.010	.050***	.009	1.000			
Urban/ Rural	.062***	-.025	-.040*	.056***	.168***	.048***	.033	.053**	.020	1.000		
Province	.008	.114***	-.086***	-.015	-.402***	.036*	-.015	.002	-.037*	-.008	1.000	
Informal Housing	.003	-.087***	.058***	-.015	.272***	-.014	-.013	-.006	.025	-.066***	-.574***	1.000
Pearson Correlations significant at p<.001***, p<.01**, p<.05* (2-tailed)												

4.6 References

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5 - Paper #4: Gender differences in longitudinal predictors of child sexual abuse in rural and urban South Africa

Under review: Sexual Abuse: A Journal of Research and Treatment



Picture: Interview under a tree, rural area, Mpumalanga

This paper addresses the study questions on risk factors for sexual child abuse victimisation in South Africa. This study specifically investigates whether factors identified as correlates by the systematic review (Paper 1) are also longitudinal risk factors and whether protective factors might moderate the relationship between the predictors and sexual abuse victimisation. The introduction provides contextual evidence and background information. The paper then details the aims, the methods and measures used for data collection, and the analytical approach. It describes the results found in five additional sections. Section one describes differences in children lost at follow-up and those retained. Section two details the socio-demographic characteristics of the sample (n=3401) and gender differences in these characteristics. Section three illustrates whether the possible risk factors identified by the systematic review (Paper 1) are cross-sectionally and prospectively correlated with contact sexual abuse at follow-up for boys and girls respectively. Section four explains the results of multivariate logistic regression

analysis investigating predictors of sexual abuse victimisation in girls. Section five illuminates the findings of the moderator analysis, which examined the relationship between the predictors and contact sexual abuse as well as potential buffering effects of protective factors. Results are then discussed in the context of international research together with implications for future research, policy and practice.

Which research questions does this paper answer?

7. What are risk and protective factors for child sexual abuse victimisation?

8. Are protective factors also possible moderators of the relationship between risk factors and child sexual abuse victimisation?

Abstract

Sexual abuse has severe negative impacts on children's lives, but little is known about risk factors for sexual abuse victimisation in sub-Saharan Africa. This study examined prospective predictors of contact sexual abuse in a random community-based sample of children aged 10-17 (n=3515, 56.6% female) in rural and urban areas in South Africa. Anonymous self-report questionnaires using validated scales were completed at baseline and at one-year follow-up (96.8% retention rate). Cross-sectional and longitudinal associations between hypothesised factors and sexual abuse were examined. Multivariate logistic regressions controlling for socio-demographics showed that for girls, previous sexual abuse (OR 3.44, 95% CI 2.03-5.60), baseline school dropout (OR 2.76, 95% CI 1.00-6.19) and physical assault in the community (OR 2.17, 95% CI 1.29-3.48) predicted sexual abuse at follow-up. Peer social support (OR .84, 95% CI .74-.98) acted as a protective factor. Previous contact sexual abuse was the strongest predictor of subsequent sexual abuse victimisation. Additionally, peer support moderated the relationship between baseline assault and subsequent sexual abuse. For boys, no longitudinal predictors for sexual abuse victimisation were identified in this sample. These results indicate that the most vulnerable girls - those not in school and with a history of victimisation - are at higher risk for sexual abuse victimisation. High levels of peer support reduced the risk of sexual abuse victimisation and acted as a moderator for those who had experienced physical assault within the community. Interventions to reduce school dropout rates and re-victimisation may help prevent contact sexual abuse of girls in South Africa.

Keywords: child abuse, adolescent abuse, sexual abuse, re-victimisation, predictors, risk factors

5.1 Background

Child sexual abuse is a global problem. It is estimated that up to 9% of girls and 3% of boys worldwide experience sexual abuse before the age of 18 (Barth, Bermetz, Heim, Trelle, & Tonia, 2013). Extensive evidence shows that sexual child abuse victimisation is associated with a variety of negative outcomes. These include an increased risk for re-victimisation (Jewkes, Levin, Mbananga, & Bradshaw, 2002), bullying victimisation (Cluver, Bowes, & Gardner, 2010), mental health distress in child- and adulthood (Collings, 1995), substance abuse (Morojele & Brook, 2006), unintended pregnancy (Reza et al., 2009) and increased risk of sexual abuse perpetration (Jewkes et al., 2006). In addition, child sexual abuse victimisation carries an increased risk for HIV infection, particularly in areas with high HIV-prevalence (Jewkes, Dunkle, Nduna, Jama, & Puren, 2010). It is therefore a major public health concern for policy makers and programmers.

Children in low-income areas of South Africa have high rates of exposure to adverse events such as community violence (Leoschut & Burton, 2006), severe poverty (Rose & Charlton, 2002) and illnesses such as HIV/AIDS (Wyk et al., 2013). They are also at high risk of sexual abuse victimisation (World Health Organization, 2010). Measured prevalence rates have been as high as 56% in males and 53% in females (Madu & Peltzer, 2000). Although there has been extensive discussion of child sexual abuse by the media and in public debate, research on predictors of sexual child abuse in South Africa has been limited. To date, studies have included cross-sectional samples of high school and university students (Anderson & Ho-Foster, 2008; Collings, 1991, 1997; King et al., 2004; Levett, 1989; Madu, 2003; Madu, Idemudia, & Jegede, 2002; Madu & Peltzer, 2000), cross-sectional, nationally-representative samples of females (Breiding et al., 2011; Jewkes, Levin, et al., 2002) or case reports of children already in contact with social or health care services (Berard & Boermeester, 1999; Carey, Walker, Roussow, Seedat, & Stein, 2008; Collings, 1993, 2005). Cross-sectional studies, however, do not allow for information regarding the direction of the correlation as both, risk factors and victimisation

are measured at the same point in time. It is therefore impossible to examine whether a factor precedes or succeeds another (Murray, Farrington, & Eisner, 2009). Studies of high school and university students may also be subject to selection bias considering that the most vulnerable youth may not attend school or qualify for university. Studies recruiting only one gender are limited in distinguishing potential gender differences in risk factors. However, all of these studies have made important contributions to creating an evidence-base to aid understanding of child sexual abuse in South Africa.

A recent systematic review (Meinck, Cluver, Boyes, & Mhlongo, 2014) investigated risk factors for child abuse victimisation in Africa. Household-level factors associated with sexual abuse victimisation were emotional abuse and physical victimisation, living in a large household, living in a non-nuclear family and receiving a disability grant (i.e., having someone in the household with a disability). Caregiver-level factors associated with sexual abuse victimisation were domestic violence, living with a step-parent, living with a single parent, parents not living together, parental rejection, substance abuse, mental health problems, punitiveness, older parents and low maternal education. Child-level correlates were school non-enrolment, child disability, child illness, externalising and internalising behaviours, knowledge of peers who had been abused and knowledge of someone having sex with a teacher. In studies that compare genders, girls were at much higher risk for sexual abuse victimisation. One study investigated and found differences in correlates between the genders. For boys, living with both a biological parent and a step-parent was associated with contact sexual abuse whilst for girls, living arrangements were not associated with risk for sexual abuse victimisation (King et al., 2004). Conflicting evidence was found regarding orphanhood status and ethnicity (Meinck et al., 2014).

However, all of these studies have been limited by their cross-sectional designs which preclude any conclusions regarding the directionality of associations and ignore intra-individual

variability, which is the fundamental nature of change over time (Cook & Ware, 1983). Whilst the systematic review (Meinck et al., 2014) did not identify poverty as a risk factor for sexual abuse victimisation in children, South African research with adult populations has identified a clear link between poverty and sexual violence (Jewkes, Sen, & Garcia-Moreno, 2002). In addition, there was no conclusive evidence regarding potential protective or buffering factors for children at highest risk (Meinck et al., 2014), although high birth order, type of parental employment and living with at least one biological parent showed protective effects in one study respectively. There is also emerging evidence from high income countries that social support may be protective of re-victimisation and may act as a moderating factor (Bender, Cook, & Kaslow, 2003; Collins, 1998; Mason, Ullman, Long, Long, & Starzynski, 2009). There is therefore an urgent need to understand longitudinal risk factors for sexual child abuse victimisation of boys and girls. In addition, it is important to investigate protective factors that may buffer those risks (Farrinton & Ttofi, 2011).

5.2 Objectives

The current study had four aims. First, we investigated associations between possible risk factors and sexual abuse in the cross-sectional follow-up data. Follow-up data were used for cross-sectional analysis because the sexual abuse measures allowed determination of past year abuse and this information was not available at baseline. Key risk factors were identified on the basis of a systematic review (Meinck et al., 2014). Second, we investigated associations between baseline risk factors and sexual abuse a year later in a longitudinal sample of South African adolescents. Third, we aimed to establish, whether these identified risk factors would also predict contact sexual abuse at follow-up if we controlled for the potential confounders age, province, and urban/rural location. Many incidents of sexual abuse and rape tend to be isolated events whereas physical and emotional abuse is often continuous and regular. Unlike many studies of physical and emotional abuse that control for baseline abuse, we aimed to

investigate whether baseline contact sexual abuse was a predictor for contact sexual abuse at follow-up. Fourth, we examined whether protective factors found in this study would buffer the relationships between the predictors and contact sexual abuse. Based on previous findings that social support may protect against re-victimisation (Bender et al., 2003; Collins, 1998; Mason et al., 2009), we hypothesised that social support would moderate the relationship between baseline risk factors and contact sexual abuse at follow-up.

5.3 Methods

5.3.1 Participants

3515 children aged 10-17 (mean age 13.5 years, 56.7% female, 50.6% urban location) were originally recruited using door-to-door sampling between January 2010 and June 2011 in rural and urban areas with HIV prevalence higher than 30% in Mpumalanga and the Western Cape provinces. Stratified random sampling of census enumeration areas was used within four health districts. Households were included in the study if a child aged between 10 and 17 years was resident. One child in each household was interviewed. When there were multiple children, one child was chosen at random. Between January 2011 and June 2012, 3401 participants (96.8% retention rate) were traced and re-interviewed.

5.3.2 Procedure

With the help of interviewers, children completed an anonymous, guided 60-minute self-report questionnaire which was translated into Xhosa, Swati, Tsonga, Sepedi and Zulu and then checked by back-translation. Participants were interviewed in a place of their choosing, i.e., empty classrooms in schools or under a secluded tree to ensure privacy and confidentiality. All participants received a certificate and refreshments. Interviewers received intensive training on working with vulnerable children and administering standardised questionnaires. Confidentiality was maintained throughout the study unless participants were considered to be

at risk of significant harm or requested help. Where this was the case, the project manager and interviewer discussed referral options with the child. Immediate referrals to local child protection or health services were made for children experiencing ongoing severe physical, sexual or emotional abuse. Where children had experienced abuse in the past, referrals to counselling centres and HIV-testing services were made when appropriate. In total, 664 referrals were made. Participation was voluntary, and informed consent was sought from participants and caregivers in their native language. Due to low literacy levels in the sampled population group, information and consent sheets were read out loud to children and caregivers, and clarification questions were answered until participants were satisfied. All survey items were pre-piloted with vulnerable youth to investigate age-appropriateness and cultural sensitivity. Ethical approval was granted by University of Oxford, University of Cape Town, Provincial Departments of Health and Education, and the National Department of Social Development.

5.4 Measures

5.4.1 Outcome

Child contact sexual abuse victimisation at baseline was measured using two items created by social workers in South Africa and one item from the National Survey of HIV and Risk Behaviour amongst Young South Africans (Reproductive Health Research, 2005). The response possibilities for all items were *binary* (0: no; 1: yes). *Contact sexual abuse victimisation at follow-up* was measured using three items based on the Juvenile Victimization Questionnaire (Finkelhor, 2005). All items were modified to fit the cultural context with help from experienced social workers and child protection NGOs as well as vulnerable children in South Africa (Table 5-1). The items showed acceptable reliability of $\alpha=.61$. However, α may be underestimated when there are only few items (Tavakol & Dennick, 2011). Item-rest correlations were therefore carried out. All item-rest correlations were substantially above the

$r=.30$ threshold recommended (Field, 2009) and ranged between $r=.39$ and $r=.49$. ‘Contact sexual abuse’ was defined as any unwanted touching or kissing, touching of private parts and/or forced intercourse experienced by the child. ‘Lifetime contact sexual abuse’ included any sexual abuse over the course of the child’s lifetime and was measured at both baseline and follow-up. ‘Last year contact sexual abuse’ included only incidents that happened in the past year and was available only at follow-up. A dichotomous variable was created for both (0: *no sexual abuse*; 1: *sexual abuse*).

Table 5-1: Questionnaire items for child sexual abuse victimisation

Source:	Question:
Baseline:	
National Survey of HIV and risk behaviour:	“Have you ever had sex with someone when you didn’t want to because they hurt you, or you were afraid that they were going to hurt you if you didn’t?”
Local social workers:	Has anyone ever... 1) touched you in a way that made you feel uncomfortable? 2) made you do something with your private parts or their private parts that you did not want to?
Follow-up:	
Juvenile Victimization Questionnaire	How often in the past year did someone... 1) touch or kiss you in a way that made you feel uncomfortable? 2) touch your private parts or asked you to touch their private parts even though you did not want this to happen? 3) force you to have sex with them in any way when you did not want to?

5.4.2 Predictors of sexual abuse?

Child physical and emotional abuse victimisation were measured using five items from the UNICEF National-level Monitoring of Orphans and Vulnerable Children Measures (Snider & Dawes, 2006) based on the Parent Child Conflict Tactics Scales (CTSPC) (Straus, Hamby,

Finkelhor, Moore, & Runyan, 1998). It measures hitting, spanking, invoking ghosts, insulting the child and threatening abandonment. This measure has not been validated in South Africa generally but was successfully used in another study in the Western Cape with good reliability ($\alpha=.70$) (Meinck, Cluver, Boyes, & Ndhlovu, 2013). The CTSPC has been used in multiple other countries (Leung, Wong, Chen, & Tang, 2008). It showed acceptable reliability in this current study ($\alpha=.69$). The frequency of abuse was measured on a four-point scale (0: *never*; 1: *at least once this year*; 2: *monthly*; 3: *weekly*). Physical and emotional abuse items were summed respectively to create two total scale scores.

Physical assault in the community was measured using an item from the Child Exposure to Community Violence Checklist (Richters & Martinez, 1993e). This asked children whether they had ever been attacked or hit while they were in the community (0: *no assault*; 1: *assault*).

School dropout and school non-attendance were measured using items devised with South African NGOs. This determined school dropout and failure to attend school for at least a week at a time. Dichotomous variables were created for school dropout (0: *child is in school*; 1: *child is not enrolled in school*) and school non-attendance (0: *child is attending school regularly*; 1: *child has missed a week or more of schooling this year*).

Domestic arguments and domestic violence were measured using two items from the UNICEF Measures for National-Level Monitoring of Orphans and Vulnerable Children (Snider & Dawes, 2006). The questions used measured incidents of domestic violence or arguments within the past week, such as ‘how many days in the past week were there adults hitting each other in your home’?

Positive parenting, consistent discipline and parental monitoring were measured using relevant sub-scales from the Alabama Parenting Questionnaire – Short form (Elgar, Waschbusch, Dadds, & Sigvaldason, 2007). Items measured parent-child interactions such as ‘your carer says you have done something well’. Frequency was measured using a five point scale (0: *never*; 1:

almost never; 2: sometimes; 3: often; 4: always). Consistent discipline and parental monitoring showed poor ($\alpha=.48-.49$) internal reliability. Positive parenting showed good reliability ($\alpha=.82$). Items within each sub-scale were summed to create a total sub-scale score.

Social support was measured using the standardised Social Support Scale which measured the existence of social support in each micro-system of family, church, school and peers (0:No; 1:Yes) (Seidman et al., 1995). The quality of this relationship - using items such as ‘this person is helpful when I have a personal problem’ - was measured on a three point scale (0: not at all; 1: sort of; 2: very). The scale was adapted to replace ‘father’ and ‘mother’ with ‘caregiver’ and to include support from religious leaders. It showed good reliability in this study ($\alpha = .76$). Items within each sub-scale were summed to create individual sub-scale scores for each micro-system.

Child Chronic Illness: Items from the Health Systems Trust South African Health Review were used to identify common chronic childhood diseases including epilepsy, asthma and tuberculosis (Ijumba & Padarath, 2006). Tuberculosis was measured using an eight item symptom checklist derived from the World Health Organization’s Practical Approach to Lung Health (Ottomani, 2005) and the South African Department of Health (2007). Children with severe pulmonary tuberculosis had to have four or more of the following symptoms: fever, fatigue, weight loss, discoloured sputum and night sweats, in addition to at least two of the following symptoms: chest pains, cough and coughing blood (Cluver, Orkin, Moshabela, Kuo, & Boyes, 2013). A dichotomous variable was coded with a child being classified as chronically ill if they responded yes to any of the health questions or had severe pulmonary tuberculosis (0: not ill; 1: ill).

Parental mortality and orphan status: Death certificates in South Africa are unreliable sources with regards to HIV/AIDS. Consequently a Verbal Autopsy Questionnaire was used (Lopman et al., 2006). This has been validated in South Africa (Hosegood, Vanneste, & Timaeus, 2004).

Determination of AIDS-related death required identification of three or more AIDS-defining illnesses (e.g., HIV-wasting syndrome, Kaposi's sarcoma or oral candidiasis). Orphanhood was defined using the UN definition as loss of one or both parents (UNAIDS, 2004). Dichotomous variables were created for AIDS-orphanhood (0: *no AIDS-orphanhood*; 1: *yes AIDS-orphanhood*) and general orphanhood (0: *not orphaned*; 1: *orphaned*).

Caregiver relationship to child: The relationship between primary caregiver and child was measured using items from the National Survey of HIV and Risk Behaviour amongst Young South Africans (Reproductive Health Research, 2005). The primary caregiver was defined as the person who 'stays and takes care of you at home'. Relationships between caregiver and child were categorised (0: *biological father; biological mother*; 1: *biological grandmother, biological grandfather*; 2: *distant relatives i.e. aunts or cousins and non biological carers*). In addition, a dichotomous variable was created for children living with least one biological caregiver (0: *not living with biological parent*; 1: *living with at least one biological parent*).

Household employment and household size were measured through a household map. Children drew their house, the people staying in each room and identified any person that was in regular, part-time, or seasonal employment. Household size was measured as the total number of people living in a household. A dichotomous variable was created for employment (0: *no household employment*; 1: *any household employment*).

Poverty was measured using an index of access to the eight highest socially-perceived necessities for children in South Africa (Barnes & Wright, 2012), such as soap to wash every day, which showed good reliability of $\alpha = .80$ in this sample. Items were reverse-scored (0: *has access to item*; 1: *does not have access to item*) and summed to give a total poverty score (i.e., total number of necessities lacking). An additional item from the South African National Food Consumption Survey that identified days per week without sufficient food in the household (Labadarios et al., 2003) was used as a proxy for severe poverty.

Demographic co-variates like age, gender, province, rural/urban location and receipt of a disability *grant* were measured using items modelled on the South African Census (Statistics SA, 2001).

5.5 Analyses

Analyses were conducted in four stages, using Stata 13. First, differences in children lost to follow-up were investigated (Table 5.2). Given evidence demonstrating higher and different risks for contact sexual abuse in girls (Edinburgh, Saewyc, & Levitt, 2006), all further analyses were conducted separately for boys and girls. Second, descriptive statistics were used to investigate socio-demographic characteristics of the sample and any gender differences in these characteristics (Table 5.3). Third, partial correlations investigating potential predictors of contact sexual abuse were conducted, adjusting for age, urban/rural location and province. These aimed to establish whether factors associated with sexual abuse in previous research were cross-sectionally (Table 5.4) and prospectively (Table 5.5) associated with sexual abuse in this sample. Fourth, factors which were shown to be correlated with contact sexual abuse at follow-up were then entered into multivariate regressions (Table 5.6).

The hypothesised predictors at baseline were entered in the first step in order to obtain unadjusted estimates for relationships between factors measured at baseline and contact sexual abuse measured at follow-up. Model 1 then adjusted for potential confounders of age, province, and rural/urban location, and Model 2 further adjusted for contact sexual abuse at baseline (Table 5.6). These models were run only for girls because of the lack of significant correlates for contact sexual abuse victimisation for boys. Finally, mean-centred interaction terms were created and entered into Model 3 in order to test whether the significant protective factors moderated relationships between the baseline risk factors and contact sexual abuse at follow-up (Table 5.6).

5.6 Results

Children lost at follow-up (n=114) (Table 5-2) did not differ from children retained at follow-up with regards to gender ($\chi^2=0.071$; $p=.789$), experience of assault in the community ($\chi^2=.022$, $p=.881$), peer social support ($z=-.917$, $p=.359$) and contact sexual abuse ($\chi^2=0.861$; $p=.353$). Children lost at follow-up were more likely to experience regular emotional abuse ($z=2.672$; $p=.008$), less likely to experience physical abuse ($z=-7.264$, $p<.001$), be older ($t=2.539$, $p=.011$), receive more teacher support ($z= 2.659$, $p=.008$), report less household employment ($\chi^2= 4.216$, $p=.040$), live in smaller households ($t=-2.567$, $p=.010$) and able to afford fewer basic necessities ($t= 4.339$, $p<.001$). Therefore, it is possible that more vulnerable children were lost to follow-up, and findings should be interpreted with this in mind.

5.6.1 Socio-demographic characteristics of the sample:

3401 children were interviewed at both baseline and follow-up (56.6% female) and analyses are limited to this group. Mean age of children was 13.4 years at baseline and 14.7 years at follow-up. 49.4% of these children came from rural areas (Table 5-3). Baseline lifetime sexual abuse prevalence was 4.4% (n=151). At follow-up, lifetime prevalence rate of contact sexual abuse was 9% (n= 306), and 5.9 % of children (n=201) reported past-year victimisation. 67% of sexual abuse victims were female.

Table 5-2: Differences between children lost and retained at follow-up

	Children Lost (n=114)	Children Retained (n=3401)	
	% (Number) or Ranksum (Number) or Mean (Standard Deviation)	% (Number) or Ranksum (Number) or Mean (Standard Deviation)	Test-statistic
Female	57.89 % (66)	56.63% (1926)	$\chi^2=0.071$, ns
School non-attendance	6.09% (7)	4.41% (150)	$\chi^2 =.733$, ns
School dropout	3.48% (4)	1.61% (55)	$\chi^2 =2.335$, ns
Contact sexual abuse	2.61% (3)	4.44% (151)	$\chi^2=0.861$, ns
Assault	11.30% (13)	11.76% (400)	$\chi^2=.022$, ns
Household employment	67.83% (78)	76.15% (2590)	$\chi^2= 4.216$, $p=.040$
Illness	11.30% (13)	12.32% (419)	$\chi^2= .107$, ns
Orphan	28.70% (33)	27.34% (930)	$\chi^2=.102$, ns
AIDS-orphanhood	18.26% (21)	12.94% (440)	$\chi^2=2.767$, ns
Living with biological caregiver	97.32% (109)	98.17% (3327)	$\chi^2=.429$, ns
Receipt of disability grant	6.09% (7)	3.79% (129)	$\chi^2=1.574$, ns
Age	13.947 (SD 2.237)	13.428 (SD 2.145)	$t=2.539$, $p=.011$
Household size	4.664 (SD 1.761)	5.175 (SD 2.092)	$t=-2.567$, $p=.010$
Able to afford necessities	3.635 (SD 2.352)	2.682 (SD 2.314)	$t= 4.339$, $p<.001$
Peer social support	28.95% (33)	31.26% (1063)	$Z=-.917$, ns
Physical abuse	0% (0)	32.67% (1111)	$Z=-7.264$, $p<.001$
Emotional abuse	44.74% (51)	34.11% (1160)	$Z=2.672$, $p=.008$
Teacher social support	55.26% (63)	42.23% (1436)	$Z= 2.659$, $p=.008$
Religious leader support	34.21% (39)	29.37% (999)	$Z=0.293$, ns
Family social support	32.46% (37)	41.37% (1407)	$Z=-1.339$, ns
Caregiver age	41.54 years (SD 12.26)	41.93 years (SD 11.29)	$t=-.356$, ns
Positive parenting	36.84% (42)	44.02% (1497)	$Z= -1.522$, ns
Parental monitoring	34.21% (39)	34.93% (1188)	$Z=.618$, ns
Consistent discipline	44.74% 3401(51)	50.04% (1702)	$Z=1.754$, ns
Domestic violence	.053 (SD .261)	.104 (SD.495)	$t=-1.09$, ns
Domestic arguments	.522 (SD .985)	.643 (SD 1.077)	$t=-1.20$, ns
t-tests (t), χ^2 -tests (χ^2), and Wilcoxon-Mann-Whitney test(Z)			

Table 5-3: Socio-Demographic Characteristics and sexual abuse prevalence and incidence

	Baseline		Follow-up	
	Boys	Girls	Boys	Girls
Gender	43.37% (1475)	56.63% (1926)	--	--
Mean age	13.41 yrs (SD 2.10)	13.44 yrs (SD 2.18)	14.63 yrs (SD 2.18)	14.70 yrs (SD 2.25)
Rural Area	42.36% (712)	57.64% (969)	--	--
Province MP	45.27% (746)	54.73% (902)	--	--
Orphan	41.88% (338)	58.12% (469)	40.78% (365)	59.22% (530)
AIDS-orphan	41.14% (181)	58.86% (259)	42.80% (217)	57.20% (290)
Caregiver Age	42.22 yrs (SD 11.46)	41.70 yrs (SD 11.14)	42.84 yrs (SD 10.70)	42.68 yrs (SD 10.70)
Main-Caregiver				
Parent	44.54% (1098)	55.46% (1367)	44.15% (1132)	55.85%(1432)
Grandparent	42.24% (166)	57.75% (227)	42.94% (149)	57.06% (198)
Other	39.03% (210)	60.97% (328)	40.55% (191)	59.45% (280)
Positive Parenting	11.69 (SD 3.67)	11.64 (SD 3.78)	11.78 (SD 4.01)	11.88 (SD 3.95)
Consistent Discipline	4.64 (SD 1.65)	4.92 (SD 2.74)	5.19 (SD 3.22)	5.21 (SD 3.43)
Parental Monitoring	2.39 (SD 2.40)	2.09 (SD 2.36)	2.66 (SD 2.56)	2.28 (SD 2.40)
Domestic Arguments	.638 (SD 1.05)	.64 (SD 1.10)	.23 (SD .77)	.31 (SD .88)
Domestic Violence	.09 (SD .45)	.11 (SD .51)	.07 (SD .05)	.11 (SD .56)
Assault experience	53.25% (213)	46.75% (187)	52.39% (208)	47.61% (189)
Physical Abuse	.73 (SD 1.16)	.80 (SD 1.29)	.59 (SD 1.00)	.59 (SD 1.06)
Emotional Abuse	.75 (SD 1.42)	.89 (SD 1.56)	.21 (SD .77)	.23 (SD .80)
Contact sexual abuse ever	25.17% (38)	74.83% (113)	33.01% (101)	66.99% (205)
Contact sexual abuse past year	--	--	30.35% (61)	69.65% (140)
School dropout	31.03% (18)	68.97% (40)	36.73% (54)	63.27% (93)
School non-attendance	45.86% (72)	54.14% (85)	46.00% (92)	54.00% (108)
Child is ill	11.66% (172)	12.82% (247)	6.95% (103)	8.18% (157)
Family support	4.87 (SD 1.10)	4.93 (SD 1.10)	5.18 (SD 1.00)	5.18 (SD 1.00)
Teacher support	4.87 (SD 3.15)	5.29 (SD 3.09)	5.36 (SD 3.17)	5.41 (SD 3.10)
Religious support	2.33 (SD 2.49)	2.89 (SSD 2.46)	4.24 (SD 3.84)	4.71 (SD 3.76)
Peer support	4.03 (SD 1.30)	4.02 (SD 1.33)	4.44 (SD 1.35)	4.34 (SD 1.34)
Household employment	43.86% (1136)	56.14% (1454)	44.25% (1155)	55.75% (1455)
Disability Grant	51.16% (66)	48.84% (63)	40% (24)	60% (36)
Food Insecurity	.80 (SD1.51)	.89 (SD 1.53)	.75 (SD 1.42)	.94 (SD 1.58)
Poverty	2.66 (SD 2.31)	2.76 (SD 2.33)	2.60 (SD 2.29)	2.74 (SD 2.33)
Household size	5.05 people (SD 1.99)	5.27 people (SD 2.16)	4.95 people (SD 1.97)	5.15 people (SD 2.24)

5.6.3 Cross-sectional associations

In accordance with the literature, cross-sectional partial correlations of the follow-up data, adjusting for socio-demographics, were conducted although they are not the focus of this paper (Table 5-4). For boys, factors positively correlated with sexual abuse were assault in the community, physical abuse, emotional abuse, food insecurity and household size. Possible protective correlates were positive parenting, consistent discipline, parental monitoring, peer support, teacher support, family support and religious leader support. For girls, factors positively associated with sexual abuse were AIDS-orphanhood, assault in the community, physical abuse, emotional abuse, domestic arguments, food insecurity and household size. Possible protective correlates were parental monitoring, family support and peer support.

5.6.4 Prospective associations

Using partial correlations adjusted for socio-demographics, none of the hypothesised factors at baseline were significantly correlated with contact sexual abuse at follow-up for boys (Table 5.5), and therefore boys were excluded from further analysis. For girls, baseline AIDS-orphanhood, caregiver age, prior physical assault, prior contact sexual abuse victimisation in the community, school dropout and food insecurity were positively associated with contact sexual abuse victimisation at follow-up. Positive parenting and peer support were protective factors (Table 5-5).

Table 5-4: Cross-sectional individual partial-correlations between hypothesized risk factors and contact sexual abuse all at follow-up

	Boys		Girls	
	<i>Partial Corr.</i>	<i>p-value</i>	<i>Partial Corr.</i>	<i>p-value</i>
Orphanhood	-.024	.361	.037	.104
AIDS-orphanhood	-.040	.120	.065*	.004
Disability Grant	-.031	.235	-.009	.692
Prior Assault in Community	.074*	.005	.071*	.002
School Dropout	-.008	.764	.030	.184
School non-attendance	-.017	.530	.019	.409
Caregiver Age	-.017	.552	.022	.375
Physical Abuse	.080*	.002	.13*	.001
Emotional Abuse	.074*	.005	.184*	.001
Domestic Arguments	.004	.089	.099*	.001
Domestic Violence	.006	.832	.037	.110
Child chronic illness	.023	.250	.080*	.001
Positive Parenting	-.067*	.010	-.079	.001
Consistent Discipline	.063*	.017	.024	.294
Parental Monitoring	.052*	.050	.054*	.018
Caregiver is biological parent or step-parent	-.005	.836	.007	.775
Family Support	-.072*	.006	-.059*	.01
Peer Support	-.063*	.015	-.064*	.005
Teacher Support	-.076*	.003	-.029	.202
Religious Leader Support	-.087*	.001	-.020	.384
Household employment	-.010	.710	.012	.587
Poverty	-.029	.267	.018	.428
Food Insecurity	.062*	.017	.083*	.001
Household size	-.052*	.046	.080*	.001

Note: * statistically significant at $p < .05$ adjusting for age, urban/rural, province

Table 5-5: Individual partial-correlations between hypothesized risk factors at baseline and child contact sexual abuse at follow-up

	Boys		Girls	
	<i>Partial Corr.</i>	<i>p-value</i>	<i>Partial Corr.</i>	<i>p-value</i>
Orphanhood	-.024	.360	.008	.733
AIDS-orphanhood	-.022	.390	.047*	.040
Caregiver Age	-.045	.085	.054*	.019
Caregiver is biological parent or step-parent	-.012	.645	.008	.740
Positive Parenting	-.013	.608	-.052*	.023
Consistent Discipline	-.033	.209	-.008	.714
Parental Monitoring	-.029	.263	.029	.210
Domestic Arguments	-.017	.520	-.002	.918
Domestic Violence	.018	.492	.018	.443
Assault victimisation	.017	.509	.075*	.001
Sexual abuse victimisation	.001	.978	.154*	.001
Physical Abuse	-.004	.878	.020	.389
Emotional Abuse	.001	.723	.022	.330
School Dropout	.011	.661	.057*	.021
School non-attendance	-.038	.142	.039	.090
Child chronic illness	.045	.074	-.010	.670
Family Support	.018	.482	-.012	.636
Peer Support	-.017	.521	-.060*	.008
Teacher Support	.014	.587	-.038	.097
Religious Leader Support	.003	.916	.018	.426
Household employment	.022	.392	-.020	.374
Disability Grant	-.035	.182	-.019	.415
Poverty	-.014	.60	.040	.078
Food Insecurity	.034	.191	.054*	.018
Household size	-.049	.060	.027	.244

Note: * statistically significant at $p < .05$ adjusting for age, urban/rural, province

Logistic regression models were then used to test predictors before adjusting for socio-demographic variables amongst girls (Table 5-6). A correlation matrix investigating the relationships between all variables in the models can be found at the end of this paper (Table 5-7). In the unadjusted model (Table 5-6, Unadjusted Model), predictors of sexual abuse victimisation at follow-up were baseline AIDS-orphanhood (OR 1.68, $p=.020$), caregiver age (OR 1.02, $p=.003$), previous assault in the community (OR 1.93, $p=.008$), school dropout (OR 2.82, $p=.019$) and food insecurity (OR 1.11, $p=.048$). Peer support (OR .85, $p=.017$) acted as a protective factor and positive parenting was no longer significant (OR .97, $p=.346$). After adjusting for baseline age, province and urban/rural location (Table 6, Model 1), predictors of sexual abuse victimisation at follow-up were baseline physical assault in the community (OR 2.12, $p=.003$) and school dropout (OR 2.49, $p=.049$). Peer support (OR .85, $p=.026$) continued to be a protective factor. A significant improvement in model fit was observed from the unadjusted model to Model 1 [$R^2=.08$, $\chi^2(3)=33.81(10)$, $p<.001$].

Baseline contact sexual abuse was a strong risk factor for sexual abuse at follow-up (OR 3.37, $p<.001$). When this was added to the model, physical assault in the community (OR 1.79, $p=.026$) remained significantly associated with contact sexual abuse (Table 5-6, Model 2). School dropout, however, was no longer a significant predictor of sexual abuse. Peer support (OR .86, $p=.039$) also remained a protective factor. A significant improvement in model fit was observed from Model 1 to Model 2 [$R^2=.09$, $\chi^2(1)=19.30(11)$, $p<.001$].

5.6.4.1 Are the relationships between prior assault, prior contact sexual abuse, school dropout and contact sexual abuse at follow-up moderated by peer support?

In order to determine whether peer social support moderated the relationship between baseline contact sexual abuse, physical assault in the community, and school dropout and follow-up contact sexual abuse in girls, three interaction terms were created (baseline sexual abuse*peer support, baseline school dropout*peers support, baseline physical assault*peer support). These interaction terms were tested in unadjusted logistic regression models including only outcome,

interaction and the two main effects of the interaction. The only significant effect in the unadjusted model was the baseline physical assault*peer support interaction. This interaction was therefore added to the multivariate linear model (Table 5-6, Model 3). The baseline physical assault*peer support interaction term remained a significant predictor of follow-up contact sexual abuse victimisation. After including the interaction term in the model, the main effects of the risk factor physical assault in the community (OR 1.70, $p=.046$) continued to be significant, as did the interaction term (OR .46, $p=.009$) (Table 5-6). The protective factor peer support (OR. 87, $p=.056$) was no longer significant. This interaction is illustrated in Figure 1 and shows that physical assault in the community is only predictive of contact sexual abuse when peer support is low. The risk for contact sexual abuse victimisation in girls with low peer support is 2.5/1000, whereas the risk for children with high peer support is 1/1000 (Figure 5-1). A significant improvement in model fit was observed from Model 2 to Model 3 [$R^2=.10$, $\chi^2(1)=6.32(12)$, $p=.01$].

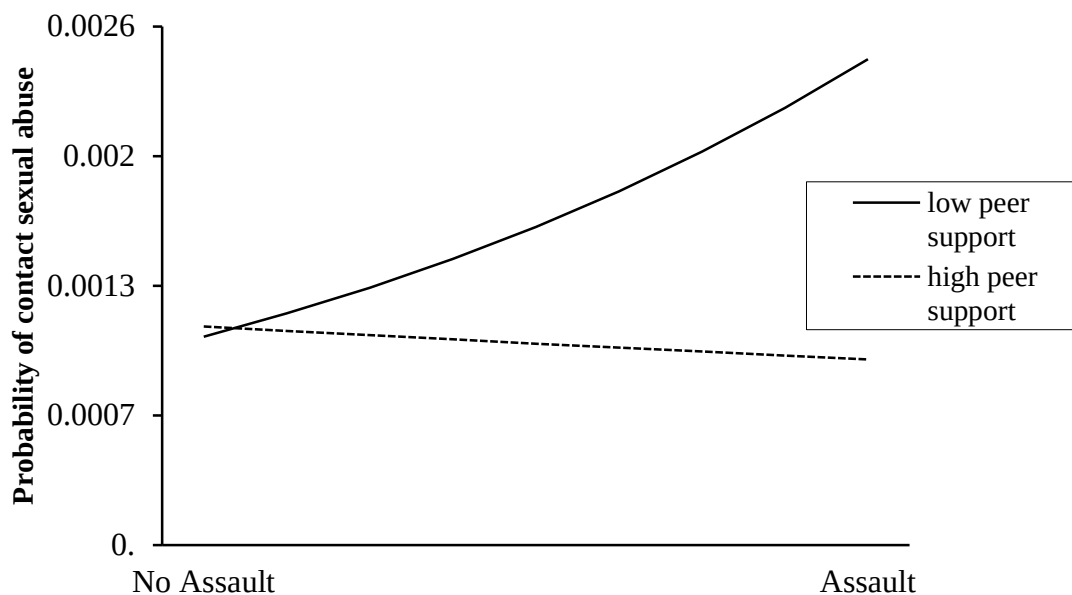


Figure 5-1: Two-way interaction between prior assault experience and peer-support in relation to contact sexual abuse at follow-up (from www.jeremydawson.co.uk/slopes)

Table 5-6: Multivariate logistic regressions of hypothesized risk factors predicting contact sexual abuse in girls (n=1926)

	Unadjusted		Model 1		Model 2		Model 3	
	OR., <i>p</i> -value	95%CI	OR., <i>p</i> -value	95%CI	OR., <i>p</i> -value	95%CI	OR., <i>p</i> -value	95% CI
AIDS-orphanhood	1.68*, <i>p</i> =.020	1.09- 2.61	1.38, <i>p</i> =.157	.88- 2.17	1.33, <i>p</i> =.225	.84- 2.10	1.35, <i>p</i> =.197	.85- 2.14
Caregiver age	1.02*, <i>p</i> =.003	1.01-1.04	1.01, <i>p</i> =.064	.99-1.03	1.02, <i>p</i> =.051	.99-1.03	1.01, <i>p</i> =.058	1.00-1.03
Assault victimisation	1.93*, <i>p</i> =.008	1.19-3.13	2.12*, <i>p</i> =.003	1.29-3.48	1.79*, <i>p</i> =.026	1.07-3.00	1.70*, <i>p</i> =.046	1.01-2.87
School dropout	2.87*, <i>p</i> =.018	1.20-6.87	2.49*, <i>p</i> =.049	1.00-6.19	2.16, <i>p</i> =.106	.85-5.48	2.05, <i>p</i> =.140	.79- 5.32
Food insecurity	1.11*, <i>p</i> =.048	1.00- 1.22	1.09, <i>p</i> = .100	.98- 1.20	1.07, <i>p</i> =.225	.96-1.18	1.06, <i>p</i> =.263	.96- 1.18
Positive parenting	.97, <i>p</i> =.346	.94-1.02	.98, <i>p</i> =.282	.93-1.02	.97, <i>p</i> =.229	.93-1.02	.97, <i>p</i> =.258	.93-1.02
Peer support	.85*, <i>p</i> = .015	.74-.96	.85*, <i>p</i> =.026	.74-.98	.86*, <i>p</i> =.039	.75-.99	.87, <i>p</i> =.056	.76- 1.00
Age			1.17*, <i>p</i> <.001	1.07- 1.28	1.14*, <i>p</i> =.005	1.04- 1.24	1.14*, <i>p</i> =.005	1.04- 1.24
Province			2.24*, <i>p</i> <.001	1.52- 3.30	2.15*, <i>p</i> <.001	1.45-3.19	2.29*, <i>p</i> <.001	1.53- 3.42
Urban/Rural			1.26, <i>p</i> =.213	.88-1.82	1.25, <i>p</i> =.233	.87-1.81	1.26, <i>p</i> =.228	.87-1.82
Baseline contact sexual abuse					3.37*, <i>p</i> <.001	2.03-5.60	3.43*, <i>p</i> <.001	2.06- 5.71
Peer Support *Assault							.46*, <i>p</i> =.009	.25- .82
R2	.04*, (<i>p</i> <.001)		.08*, <i>p</i> <.001		.09*, <i>p</i> <.001		.10*, <i>p</i> =.01	
Δ in Chi2			33.81		19.30		6.32	
-2*LL	-.472.87		-455.97		-446.32		-443.16	

Note: * statistically significant at *p* < .05

5.7 Discussion

This is the first known prospective study investigating risk and protective factors for sexual abuse in South Africa. In addition, it is the first to provide prevalence rates for contact sexual abuse in a large community-based sample of South African children. Other available studies used samples of either high school and university students or children seeking social or health services. The only two community-based studies in the region exclusively recruited females from a much older age group (Jewkes, Levin, Mbananga, & Bradshaw, 2002).

5.7.1 Cross-sectional associations

A number of hypothesised factors found to be associated with contact sexual abuse in other cross-sectional studies in Africa were also found to be cross-sectionally associated in this study (Meinck, Cluver, Boyes, & Mhlongo, 2014). For boys, these factors focused on prior or concurrent victimisation such as assault in the community, poverty, and physical and emotional child abuse victimisation. There were also potential protective factors for boys including parenting style, smaller household size and social support networks such as peers, religious leaders, teachers and family.

For girls, cross-sectional associations included general vulnerabilities such as AIDS orphanhood, poverty and chronic child illness. Prior or concurrent victimisation, such as assault in the community, domestic arguments, and physical and emotional abuse, was also associated. Potential protective factors were parental monitoring and family and peer support. These findings correspond to evidence from a recent systematic review (Meinck et al., 2014) and add evidence on how gender impacts risk factors for sexual abuse victimisation. Other factors established by the systematic review such as caregiver age, child illness, orphanhood, receipt of a disability grant (disability within the home), school non-attendance, domestic violence,

household employment and caregiver relationship to child were not cross-sectionally associated in this study.

5.7.2 Longitudinal associations

Unexpectedly, none of the associated factors previously identified in cross-sectional studies were confirmed in this longitudinal sample with regards to boys. This may be due to the fact that research has consistently found a higher risk for sexual victimisation for girls (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), and previous results in studies of mixed gender were carried by the results in the female group. However, it is also possible that the number of boys reporting contact sexual abuse (n=64) was too small to yield statistical power despite the large sample size. Further longitudinal research on contact sexual abuse amongst boys is needed before any conclusions can be drawn.

With regards to girls, AIDS orphanhood, caregiver age, previous assault in the community, school dropout and food insecurity were prospectively associated with contact sexual abuse at follow-up in the unadjusted model. Peer support acted as a protective factor. After adjusting for socio-demographic characteristics, school dropout and physical assault in the community measured at baseline were predictive of contact sexual abuse one year later. Peer support acted as a general protective factor, lowering the risk for contact sexual victimisation, and also moderated the relationship between assault and sexual abuse. The strongest predictor of contact sexual abuse at follow-up was contact sexual abuse at baseline. Even then, however, assault in the community remained a risk factor and peer support remained a protective factor.

These findings extend previous cross-sectional findings from sub-Saharan Africa (Birdthistle et al., 2011; Breiding et al., 2011; Dunkle et al., 2004) and high income countries (Boney-McCoy & Finkelhor, 1995). They are also consistent with findings from longitudinal studies in the United States (Classen, Palesh, & Aggarwal, 2005). The findings demonstrate that sexual

abuse victimisation affects the most vulnerable South African girls: those who have already been victimised, either sexually or physically, and those who are not attending school. This study contributes to accumulating evidence that demonstrates important differences in perpetrators and predictors of different types of abuse. Whilst risk factors for physical and emotional abuse are mainly situated within the family and household, the majority of contact sexual abuse in adolescents is perpetrated by intimate partners, peers and more distant relatives as well as strangers (Reza et al., 2009). The risks of sexual abuse victimisation also appear to be closely associated with school-level and community-level disadvantage.

There are a number of possible reasons for why baseline community assault, school dropout, previous sexual abuse victimisation and peer social support seem to be the only robust predictors over time. As in many other studies, one potential explanation is low reporting, resulting in small numbers of children disclosing contact sexual abuse. In addition, factors which may co-occur simultaneously might not necessarily retain their correlation across different points in time. This study measured past-year prevalence of sexual abuse at follow-up, and children might have not experienced certain risk factors at baseline which they then had experienced at follow-up and vice versa. This phenomenon could be investigated further using time series analyses. Furthermore, age effects may be a reason for why certain factors do not predict sexual abuse over time as different age groups have dissimilar risks for child abuse victimisation (Cook & Ware, 1983), with older children at higher risk than younger children.

Consistent with previous research, peer support was protective against re-victimisation. Moreover, peer support was a significant moderator of the prospective relationship between assault and contact sexual abuse victimisation in girls. Specifically, girls who had experienced baseline physical assault in the community and low peer support were at higher risk for contact sexual abuse victimisation at follow-up. Girls who had been physically assaulted and experienced high levels of peer support at baseline had no increased risk for contact sexual

abuse victimisation at follow-up. However, peer support did not buffer the effect of previous sexual abuse victimisation and school dropout on the risk for contact sexual abuse at follow-up. It should be noted that research on peer support as a moderator of re-victimisation in adolescents has thus far focused mostly on peer victimisation through bullying and not on contact sexual abuse (Boulton, Trueman, Chau, Whitehand, & Amatya, 1999; Hodges, Boivin, Vitaro, & Bukowski, 1999). Emerging evidence with adult women shows mixed results regarding the buffering effects of social support on risk factors for sexual abuse or domestic violence re-victimisation (Bender, Cook, & Kaslow, 2003; Bybee & Sullivan, 2005; Mason, Ullman, Long, Long, & Starzynski, 2009). Further research is needed to identify and confirm the moderating effects of social support on the relationship between victimisation and contact sexual abuse in girls. This is likely relevant for targeting interventions and identifying children most at risk.

While evidence from sub-Saharan Africa suggests high levels of sexual abuse by teachers and fellow learners (Burton & Leoschut, 2013; Human Rights Watch, 2001; Leach, 2002), the results of this study suggest that school enrolment may protect children from sexual abuse victimisation. The underlying mechanism might be that school allows children to build networks with peers and offers a structured and protected environment independent of the community. In addition, children with strong social support networks show higher levels of self-esteem and self-efficacy and therefore may be less vulnerable targets for perpetrators of sexual abuse (Colarossi & Eccles, 2003; Egan & Perry, 1998).

These results suggest that targeting school dropout and re-victimisation could be important steps towards reducing the risk of contact sexual abuse victimisation in girls in South Africa. Research shows that there are a number of effective interventions for keeping girls in school, including cash transfer programmes such as the South African child support grant or the old age pension (Budlender & Woolard, 2006; Heinrich, Hoddinott, & Samoson, 2012; Woolcock,

Özler, Baird, & Ferreira, 2013), school feeding schemes (Bundy et al., 2009), support for school fees and materials (Hallfors et al., 2011), support for students with lower attainment, support for adolescent mothers (Panday, Makiwane, Ranchod, & Letsoalo, 2009) and reductions in secondary school fees (Borkum, 2009). Additionally, providing support services to victims and their families as well as improving child protection services can prevent further re-victimisation (Lalor & McElvaney, 2010). There is emerging evidence to show that interventions that provide information about sexual abuse prevention and help survivors to spot and deal with risky situations can be successful at preventing re-victimisation in adolescents (DePrince, Chu, Labus, Shirk, & Potter, 2013). Future research examining the potential protective role of peer support to inform interventions could help to reduce rates of sexual abuse of girls, especially for girls with histories of victimisation. Interventions that promote social support in schools (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011) could be considered. In addition, after-school activities may widen children's social networks (Durlak, Weissberg, & Pachan, 2010), and helping isolated children to develop social skills can increase their chances of making friends (Oden & Asher, 1977) whilst keeping them in a safe and structured environment.

5.7.3 Limitations

This study had a number of limitations. Due to low levels of literacy, the study used child self-report in interviewer-guided interviews, and as a result, some under-reporting may have occurred. However, this approach also allowed for development of good interviewer-child relationships which facilitated follow-up, as demonstrated in the exceptionally high retention rate. These relationships facilitated discussions about referrals following disclosure of abuse victimisation. Second, the study was carried out in randomly selected areas with HIV prevalence above 30%. Results, therefore, cannot be generalised across the population of South African children. Although we cannot generalise about South Africa's child population as a

whole, our findings provide a good indication of the risk factors for children in areas with high HIV prevalence and high levels of poverty. Third, questionnaires measuring abuse victimisation have not been validated in South Africa. However, all items had been used in a previous study (Meinck, Cluver, Boyes, & Ndhlovu, 2013) and showed good reliability in this sample. Fourth, there is a strong likelihood of unmeasured confounding variables in this study, as suggested by the low values of R^2 . Even though models adjusted for potential confounding variables reported by children, we could not account for caregiver-related confounders such as mental health and substance use. Due to the design of the study, we cannot rule out unmeasured confounding variables. Future research could investigate risk factors in matched case-control designs. Finally, hypothesised risk factors were limited to those which could be reported by a child. Future work is needed to examine potential risk factors at the parent/primary caregiver level, such as caregiver substance abuse (Madu, Idemunda, & Jegede, 2003; Vogeltanz et al., 1999), mental health (Fleming, Mullen, & Bammer, 1997) and childhood abuse victimisation of caregivers (McCloskey & Bailey, 2000) to allow for a more holistic picture of risks for sexual abuse victimisation in South Africa.

5.7.4 Applicability/Implementation

The findings of this study demonstrate the magnitude of the problem of sexual abuse victimisation and elucidate prospective risk and protective factors associated with sexual abuse. They also highlight the importance of school enrolment and strong social support networks, especially following victimisation. In particular, interventions that increase school enrolment and prevent school dropout as well as those that improve child-peer interaction may have additional positive impacts on reducing the risk for sexual abuse. Interventions to reduce girls' vulnerability to contact sexual abuse should be rigorously developed and tested prior to scale-up.

Table 5-7: Correlation matrix of all variables in the model

	Sexual Abuse T2	Sexual Abuse T1	AIDS Orphanhood	Caregiver Age	Assault Victimization	School Dropout	Poverty	Positive Parenting	Peer Support	Age	Province	Urban/Rural
Sexual Abuse T2	1.000											
Sexual Abuse T1	.128***	1.000										
AIDS-Orphanhood	.041*	.036*	1.000									
Caregiver Age	.035**	.007	.062**	1.000								
Assault victimisation	.044**	.116***	.028	.012	1.000							
School Dropout	.047**	.063**	-.008	.003	.018	1.000						
Poverty	.052**	.071***	.084***	.023	.086***	.032	1.000					
Positive Parenting	-.030	-.002	-.030	-.009	-.033	-.057**	.011	1.000				
Peer Support	-.043*	.002	-.030	-.032	.009	-.004	.031	.097***	1.000			
Age	.102***	.116***	.095***	.102***	.110***	.087***	.073***	-.071***	.024	1.000		
Province	.084***	.031	.096***	.106***	-.128***	-.045**	-.036*	.161***	-.002	.002	1.000	
Urban/Rural	.042*	.041*	.034*	.030	-.016	.032	.012	-.018	-.035*	.053**	-.008	1.000
Pearson Correlations significant at p<.001***, p<.01**, p<.05* (2-tailed)												

5.8 Bibliography

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6 - Summary and discussion of thesis findings.

The research and findings presented in this thesis explore risk factors for child abuse victimisation in South Africa. This thesis had three aims: 1) to carry out a systematic review of studies in Africa that investigated risk factors for physical, emotional and sexual child abuse victimisation; 2) to establish incidence, prevalence, perpetrators and locations for physical, emotional and sexual child abuse victimisation in South Africa; and 3) to examine risk factors for child abuse victimisation in South Africa found in cross-sectional samples and test whether they predicted physical, emotional or sexual child abuse in a longitudinal sample of South African children. Findings offered insights into ways in which interventions can be targeted to reach children at highest risk of abuse victimisation. They provided evidence of South Africa's child abuse problem and identified risk and protective factors that practitioners and policy makers can use to design suitable interventions for child abuse prevention.

This information fills an important gap in the literature. Thus far, South African research has examined the negative impact of abuse victimisation on children (Jewkes, 2004; King et al., 2004; Mathews, Abrahams, Jewkes, Martin, & Lombard, 2013; Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004). In addition, research has been carried out on correlates of child abuse in cross-sectional samples of groups of high school and university students (Anderson & Ho-Foster, 2008; Collings, 1991; Madu, Idemudia, & Jegede, 2002; Madu, Idemunda, & Jegede, 2003; Madu & Peltzer, 2000, 2001). However, no research with longitudinal samples is available, and none of the studies used child current self-report in community-based samples. This study provides a deeper understanding of the prevalence, incidence and risk factors for child abuse victimisation in a community-based sample. As a result, it helps to identify ways in which interventions may target vulnerable families and reduce risk factors for child abuse victimisation. This chapter draws together interpretations of key findings, limitations of the study, implications for policy and practice, and directions for future research.

6.1 Paper #1: Systematic review of the literature: What is the evidence-base for correlates of physical, emotional and sexual child abuse in Africa?

The first paper of this thesis was a systematic literature review which aimed to synthesise existing evidence and inform the research study. The systematic review found that empirical research on risk and protective factors for child abuse is limited in Africa. The majority of studies were from South Africa and Egypt. Few studies investigated physical abuse and almost no evidence was available for emotional abuse victimisation. A larger number of studies on sexual abuse had been conducted. The reviewed studies suffered from wide heterogeneity in terms of sample, scales used, recruitment, and definitions of physical, emotional and sexual child abuse. Prevalence rates of physical, emotional and sexual abuse were high across studies.

The review was able to identify correlates of abuse on all levels of the Ecological Framework (Belsky, 1993), and the most reported factors will be summarised below. For physical abuse, domestic violence was the factor most commonly associated on the caregiver level. This co-occurrence of exposure to domestic violence and physical abuse has also been reported from high income countries and appears to increase the risk for negative outcomes for abused children (Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008). Another factor identified by a number of studies was caregiver illness. When living with someone with a chronic illness, HIV in particular, or a disability, children were more likely to report physical abuse. This may be due to increased family stress caused by high levels of stigma and poor mental health. In addition, parent-child relationships can suffer due to parental experience of chronic pain which can increase inconsistent parenting (Black, Heyman, & Smith Slep, 2001b; Evans, Shipton, & Keenan, 2006; Stith et al., 2009). Poor caregiver mental health was also found to be correlated with physical abuse victimisation. This corresponds with findings from high income countries (Black, Heyman, & Smith Slep, 2001a). In addition, there are strong links between poor maternal mental health and domestic violence (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008).

Households with caregivers suffering from chronic illnesses are also at higher risk for income deprivation, particularly if they come from communities with high disease burdens and restricted access to healthcare. At the household level, poverty was also found to be associated with physical abuse victimisation. Evidence from high income countries corroborates this finding. Thus far, it is unclear why poverty co-occurs with an increased risk for physical abuse victimisation. Some of the underlying causes could be increased family stress (Gershoff, Aber, Raver, & Lennon, 2007) or living in underprivileged, more violent areas (Pinderhughes, Nix, Foster, Jones, & The Conduct Problems Prevention Research, 2001).

At the child level, younger age was the most common factor associated with physical abuse. Evidence suggests that younger and smaller children as well as those in early stages of development appear at higher risk for physical abuse (World Health Organization, 2002). This is particularly true for fatal child abuse (Keenan et al., 2003). School non-achievement was also associated with physical abuse victimisation, but it was unclear whether non-achievement might be a result of physical abuse victimisation. This finding corresponds to evidence from high income countries where lower educational attainment was associated with physical abuse (Kurtz, Gaudin Jr, Wodarski, & Howing, 1993).

Very little evidence is available about correlates of emotional abuse in Africa. In the reviewed studies, the most common factor associated with emotional abuse was domestic violence. Little evidence about risk factors for emotional abuse is available from high income countries, but the available evidence corresponds with this finding (Black, Smith Slep, & Heyman, 2001).

Correlates for sexual abuse were also found on all levels of the Ecological Framework (Meinck, Cluver, Boyes, & Mhlongo, 2014). In particular, the relationship status of the parent (i.e., if they were single or divorced) or living with a step-parent were found to be associated with sexual abuse victimisation. This has also been reported from high income countries (Black, Heyman, et al., 2001a) although it is unclear why children in those families are more vulnerable.

Another common risk factor found by the review was domestic violence, and evidence from the United States showed that domestic violence increased the risk for incestuous sexual abuse (Stroebe et al., 2013). In the African context, all sorts of sexual abuse experience were measured, not only intra-familial sexual abuse. Poor parent-child relationship was also a common factor associated with sexual abuse. As in high income countries, poor-mother daughter relationships in particular increased the risk for sexual abuse (Black, Heyman, et al., 2001b). Another common factor was poor parental mental health. Whether poor parental mental health is preceded or succeeded by child sexual abuse is unclear, even though longitudinal evidence from high income countries suggests that mothers of sexually abused children experience higher levels of stress and anxiety than those of non-abused children (Pianta, Egeland, & Erikson, 1989). A number of studies reviewed also found parental drug and alcohol use to be associated. As different types of substances may predict different types of abuse, it is unclear thus far what the mechanisms between substance abuse and sexual child abuse victimisations are (Famularo, Kinscherff, & Fenton, 1992; Walsh, MacMillan, & Jamieson, 2003).

Where studies were not of single gender only, being female was commonly associated with sexual abuse on the child level. This corresponds to global evidence on sexual child abuse (Pereda, Guilera, Forns, & Gómez-Benito, 2009) but does not take into account that boys may be less likely to disclose sexual abuse due to higher levels of stigmatisation (Spaventa, 2007).

On the household level, physical and emotional abuse were identified as risk factors. Evidence suggests that it is common for multiple types of child abuse to co-occur (Herrenkohl & Herrenkohl, 2009). Large family units were also found to be associated with sexual abuse victimisation, and there is a current debate in sub-Saharan Africa whether over-crowding may facilitate sexual abuse due to the necessity of co-sleeping and the lack of privacy (Richter, Stein, & Cluver, 2009).

6.2 The main study: Method summary

Building on evidence from the systematic review, a longitudinal study on prevalence, incidence, perpetrators, locations and risk factors for physical, emotional and sexual abuse was conducted. 3515 children aged 10-17 were recruited from two urban and two rural health districts in two provinces (Mpumalanga and the Western Cape) with >30% HIV-prevalence (Department of Health, 2009). In each district, census enumeration areas were randomly selected and door-to-door sampling was used to identify households with a resident adolescent. Baseline data were collected between January 2010 and June 2011. Follow-up occurred with 3401 participants (96.8%) a year later. The study was part of the Young Carers Project, a collaboration amongst the Universities of Oxford, Cape Town and KwaZulu-Natal; the South African government; and national and international NGOs.

6.3 Paper #2: What are prevalence and incidence rates of physical, emotional and sexual child abuse in South Africa?

The second paper in this thesis aimed to investigate incidence, prevalence, perpetrators and locations of physical, emotional and sexual abuse victimisation. It also examined the socio-demographics of physical, emotional and sexual abuse. Overall, participants reported a high incidence of frequent (monthly) physical (11.8%), emotional (10.2%) and contact sexual abuse (2.7%) as well as sexual harassment in the past year (9%). A high prevalence of monthly physical (16.6%) and emotional (20.7%) abuse in the past year was reported in addition to lifetime contact sexual abuse including rape (9%) and lifetime rape (3.3%). Rates of multiple abuse victimisation were reported, with girls and older children at particular risk. 9.2% of children reported frequent physical and emotional abuse; 1.6% reported frequent emotional and contact sexual abuse; 0.8% reported frequent physical and contact sexual abuse; and 0.6% reported frequent physical, emotional and contact sexual abuse. Prevalence rates of child abuse found in this study are similar to those found in recent studies of similar age groups (13-17) from Tanzania and Kenya (UNICEF, 2012, 2011), particularly when considering that the risk

for sexual abuse victimisation is highest in late adolescence. While comparisons of child abuse victimisation are problematic due to the high possibility of under-estimations, the similar findings across studies suggest very high rates in Eastern and Southern Africa compared to studies from high income countries (Crouch, Hanson, Saunders, Kilpatrick, & Resnick, 2000; Finkelhor & Dziuba-Leatherman, 1994; May-Chahal & Cawson, 2005; Radford, 2013).

6.3.1 What socio-demographic factors put children at higher risk of abuse?

While younger children experience more physical abuse, older children were more likely to report sexual abuse and multiple abuse victimisation. This finding seems broadly in line with literature from other studies in Africa (as shown by a recent systematic review) and in high-income country contexts (Black, Smith Slep, et al., 2001; Cyr et al., 2013; Meinck et al., 2014). Older age for sexual abuse and younger age for physical abuse have been shown to interact with ethnicity and severity of abuse in other studies (Black, Heyman, et al., 2001a).

Girls were more likely than boys to report emotional abuse, lifetime sexual abuse and multiple abuse victimisation, findings which correspond to global evidence (Pereda et al., 2009; Putnam, 2003). Frequent rape and contact sexual abuse victimisation were equally reported by males and females. However, the number of children reporting contact sexual abuse and rape was too small in this sample to yield robust results (n=94). For emotional abuse, only one study in South Africa previously examined gender differences (Thurman & Kidman, 2011). Thus far, evidence from other countries is inconclusive regarding gender differences in physical and emotional abuse victimisation (Black, Heyman, et al., 2001a; Black, Smith Slep, et al., 2001).

6.3.2 Who are the perpetrators and what locations do they use?

Findings show consistent differences between the perpetrators of physical/emotional abuse and sexual abuse. While the majority of physical abuse was committed by caregivers and teachers within the home and school, emotional abuse was perpetrated mostly by caregivers and other

relatives within the home and the child's community. Sexual abuse victimisation was mostly perpetrated by girlfriends/boyfriends or peers, and occurred mostly within schools and the community. The majority of rapes were committed by strangers within the community.

Since caregivers are usually the main disciplinarians of their children's behaviour, spend a large amount of time with their offspring and may consider physical discipline a behaviour measure (Dawes, De Sas Kropiwnicki, Kafaar, & Richter, 2005), it is not surprising that they are the main perpetrators of physical and emotional abuse (Cicchetti & Carlson, 1989; Garbarino, Guttman, & Seeley, 1986; Glaser, 2002). However, previous evidence suggests that physical punishment remains common in schools across the country despite the abolition of corporal punishment in schools (Morrell, 2001; South African Human Rights Commission, 2013). Our findings are consistent with these studies.

The most common perpetrators of rape were strangers, peers and relatives, findings which correspond to other studies in South Africa (Anderson & Ho-Foster, 2008; Collings, 1991; Jewkes, Levin, Mbananga, & Bradshaw, 2002). Contact sexual abuse and sexual harassment were mostly carried out by peers/friends or relatives, and this finding is corroborated by other South African studies (Madu & Peltzer, 2001). Contrary to other studies carried out in South Africa, few children reported teachers as sexual abusers (Prinsloo, 2006).

6.4 Paper #3: Do disability and poverty mediate the relationship between household chronic illness and physical and emotional abuse?

The third paper of the thesis aimed at investigating the relationships between physical and emotional abuse and the potential risk factors of household chronic illness, disability and poverty, based on evidence from the systematic review (Meinck et al., 2014). Direct and indirect effects of household illness on frequent physical and emotional abuse were investigated using multiple mediation analysis (Hayes, 2009). We hypothesised that the relationship

between household illness and physical and emotional abuse would be mediated by the extent of the ill person's disability and poverty.

There was a direct effect of household AIDS-illness on frequent physical and emotional abuse in boys and frequent physical abuse in girls, findings which correspond to previous South African research (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Meinck, Cluver, Boyes, & Ndhlovu, 2013). Mediation analyses showed that poverty, but not disability, partially mediated the relationship between family AIDS-illness and physical and emotional abuse.

Households affected by AIDS are constantly linked to higher levels of deprivation (Gilborn, Nyonyintono, Kambumbuli, & Jagwe-Wadda, 2001) due to inability to work, high funeral costs and medical expenses (Leibbrandt, Poswell, Naidoo, Welch, & Woolard, 2004). In addition, people living with AIDS often suffer from chronic fatigue and physical disabilities as symptoms of their illness (Albert et al., 1994; Crystal, Fleishman, Hays, Shapiro, & Bozzette, 2000; Ferrando et al., 1998).

There was no direct effect of other chronic illnesses in the household on physical or emotional abuse for boys and girls. Poverty and the extent of the ill person's disability, however, were full mediators of the relationship between physical and emotional abuse in boys. For girls, disability was a full mediator of the relationship between other chronic illness and physical abuse. Poverty was a full mediator of the relationship between other chronic illness and emotional abuse. Households affected by chronic illness were at low risk for poverty relative to those affected by AIDS, which might be due to older people suffering from chronic illness (Gómez-Olivé, Thorogood, Clark, Kahn, & Tollman, 2013) and their entitlement to the old age state pension. However, poverty was still linked to child abuse in families affected by chronic illness.

There are various possible routes through which poverty might increase the risk of abuse. Previous research shows that poverty and poor physical health predict increased psychological stress (Kelley, Whitley, Sipe, & Crofts Yorker, 2000). Caregiver depression is associated with

lower economic status and lower social support (Kagotho & Ssewamala, 2012) and is further exacerbated by food insecurity (Kuo, Operario, & Cluver, 2012). Poor parental mental health has been found to be a risk factor for physical and emotional abuse across contexts (Meinck et al., 2014). In addition, HIV-positive parents and those in chronic pain show poorer parent-child relationships, more inconsistent parenting (Armistead & Forehand, 1995; Evans et al., 2006; Steele, Forehand, & Armistead, 1997) and less positive parenting (Lachman, Cluver, Boyes, Kuo, & Casale, 2013).

There are also a number of ways in which disability and risk for child abuse may be linked. Larger number of symptoms and higher extent of disability were found to be associated with higher parental distress and aggravation during parenting tasks (Annunziato, Rakotomihamina, & Rubacka, 2007). Illness-related demands also predict lower parenting quality which in turn predict child behaviour problems (Lewis & Hammond, 1998).

It is therefore possible that chronic illness, disability, poverty and poor mental health may all result in higher levels of stress which increase the risk for physical and emotional child abuse victimisation (Stith et al., 2009).

6.5 Paper #4: What risk factors predict sexual child abuse?

The fourth paper of this thesis investigated predictors for child sexual abuse in South Africa. Drawing on the systematic review, there are multiple potential risk factors for child sexual abuse victimisation in South Africa. This study investigated whether factors identified by the systematic review (Paper 1) were associated with contact sexual abuse in boys and girls separately. It then examined possible moderation of the relationship between risk and protective factors and contact sexual abuse.

For boys, none of the factors associated with contact sexual abuse in the systematic review were prospectively associated with contact sexual abuse in this study. Using multivariate analysis, school dropout and previous assault were predictive of contact sexual abuse at follow-up for girls, with peer support acting as a protective factor. Assault in the community remained a significant risk factor and a peer support a protective factor independent of baseline contact sexual abuse. These findings suggest that contact sexual abuse affects two vulnerable groups in South Africa: girls who have been previously victimised and those who have dropped out of school. Findings are in line with cross-sectional evidence from South Africa (Birdthistle et al., 2011; Breiding et al., 2011; Dunkle et al., 2004) and longitudinal evidence from high-income countries (Classen, Palesh, & Aggarwal, 2005). Knowing that the majority of contact sexual abuse is perpetrated by peers, distant relatives and strangers (see Paper 2), it appears that the risk of sexual abuse victimisation for girls in South Africa seems to come from the wider community rather than the family, which is the case with physical and emotional abuse.

Surprisingly, a number of correlates identified by the systematic review were not found to be associated with contact sexual abuse in this study. Domestic violence, previous physical and emotional abuse victimisation, and school non-attendance in particular had been identified by several studies and did not predict contact sexual abuse in this sample. This may be because the associated factors might not have retained their association over different points in time.

Peer support acted as a significant moderator of the relationship between baseline assault and contact sexual abuse at follow-up in girls. Girls who had been assaulted previously but reported higher levels of social support also reported less contact sexual abuse victimisation. These findings extend previously-existing evidence on peer support as a moderator of re-victimisation for adolescent victims of bullying (Boulton, Trueman, Chau, Whitehand, & Amatya, 1999; Hodges, Boivin, Vitaro, & Bukowski, 1999) and female adult victims of domestic violence and sexual abuse (Bender, Cook, & Kaslow, 2003; Bybee & Sullivan, 2005; Mason, Ullman, Long, Long, & Starzynski, 2009). Interventions to increase peer support and prevent school dropout and re-victimisation may be beneficial in lowering risk of contact sexual abuse in girls in South Africa.

6.6 Strengths of the study

This is the first study to provide information on prevalence, incidence and evidence on risk factors in a longitudinal community-based sample in South Africa.

6.6.1 Measuring child abuse

Measurement of child abuse victimisation is difficult and has been contested due to a variety of issues discussed below. This study used interviewer-assisted questionnaires and child current self-report. This approach built a good interviewer-participant relationship, which allowed for clarification of questions and answers, facilitated follow-up and referrals, and reduced the amount of missing data (<.5%). Like all studies using self-report, this design carries the risk of social desirability bias. Children might think that they are expected to say that they have been abused, resulting in over-report of abuse victimisation. There is, however, no indication of this behaviour within this sample. Recruiting children known to social services is even less reliable. Estimates indicate that the majority of children who experience abuse are not known to child protective services in high income countries (Sedlak & Broadhurst, 1996). Using only substantiated cases of child abuse would describe only the tip of the iceberg of those children

experiencing abuse significant enough to be registered by relevant agencies. Emerging research also shows that the number of substantiated cases is highly dependent on the availability and resources of child protection agencies (Stephens-Davidowitz, 2013). In developing countries such as South Africa, child protective systems are highly constrained, under-resourced and often unable to deal with very large caseloads (Lachman, 1996).

In child abuse research, under-reporting is much more common than over-reporting, particularly concerning undesirable events such as sexual abuse (Finkelhor, 1993). Computer-assisted interviewing may increase reporting of stigmatised events or behaviours in some cases (Richens et al., 2010); however, it may not be suitable for all settings, such as the very rural ones (in which parts of this study were conducted) where participants may be intimidated by using a computer to answer questions (Mensch, Hewett, Gregory, & Helleringer, 2008; Potdar & Koenig, 2005). Existing research has found conflicting evidence as to whether interviewer-guided or paper questionnaires result in higher rates of disclosure (Martin, Anderson, Romans, Mullen, & O'Shea, 1993; Wyatt & Peters, 1986).

Evidence has shown, however, that children can give reliable information about traumatising events that can be as reliable as an adult's, depending on the circumstances surrounding the disclosure, although reliability increases with age (Ceci & Bruck, 1993). For younger children in particular, parental report of child victimisation would have been feasible but may not be reliable given that abuse may be intra-familial, causing hesitancy to disclose. Parents might also have limited knowledge about incidents of abuse victimisation in their child's life (Finkelhor, Moore, Hamby, & Murray, 1997).

This study used precise definitions of child abuse and the frequency with which it occurred. Lack of comparability with other studies is also grounded in the fact that they used different definitions for child abuse. Some defined abuse as parental conduct, some used risk of harm and others used a mixture of both (Besharov, 1981). In addition, severity and occurrence of

abuse are often not clearly defined. In some studies, children who experienced a single incident of one type of abuse may be classified together with children who experience frequent and very severe abuse (Kinard, 1994). This study considered children to be abused if they experienced physical or emotional abuse on a monthly or more frequent basis. For contact sexual abuse, this study required children to have experienced unwanted sexual touching, sexual kissing or forced penetration in the past year. Thus, this study used more stringent and concise definitions of child abuse than many other studies in Africa.

Another difficulty in child abuse measurement is the co-occurrence of different types of abuse. This raises the question of whether multiple victimisation is experienced by the majority of maltreated children, as shown in other studies (Kaufman & Cicchetti, 1989), or whether these children are in the minority. Children who are victims of multiple abuse types may have reported only one type of abuse, but even when children report having experienced all types of abuse, overlap of multiple abuse categories may hamper predictor analyses (Kinard, 1994). In this study, there was considerable co-occurrence of physical and emotional abuse. 9.2% of participants reported frequent co-occurring physical and emotional abuse victimisation. This is a considerable number of the overall participants who disclosed frequent physical (16.6%) and emotional (20.7%) abuse. For this reason, the same hypothesised risk factors were investigated for physical and emotional abuse. It is important to consider that risk factors and interventions for multiple abuse victimisation are likely different, and future research is needed.

Since the study design was that of a prospective cohort study, abused and non-abused children were not matched. This highlights the importance of adjusting for confounding effects such as socio-demographics. There are no guidelines or systematic approaches regarding the number and type of confounders for which adjustments need to be made. Previous studies have adjusted for a wide variety of confounders ranging from age, gender, income, parental abuse victimisation during childhood, parental education and attitudes towards parenting. However,

many of the potential confounders could also be considered risk factors, i.e., parental age (Mash & Wolfe, 1991) Even if we adjust for all of these factors, a certain degree of uncertainty remains regarding the abuse status of children in the non-abused group (Kinard, 1994). This study therefore used a number of adjustment variables which were in line with previous research from South Africa.

6.7 Limitations of the study

While this study had a number of strengths, it also had several limitations.

6.7.1 Measuring child abuse

It has been suggested that researchers should use categorical variables instead of dichotomous ones, reflecting the heterogeneous nature of child abuse victimisation (Hulme, 2004). Since the vast majority of studies to date used binary variables, however, this study also did so with regards to each paper's main outcome in order to facilitate comparability.

Furthermore, at baseline, the study only used few child abuse measures as child abuse was considered as a mediator or risk factor rather than an outcome. For the follow-up data collection, further items to measure abuse were added for physical and emotional abuse to the already existing ones. For sexual abuse, old items were replaced with more sensitive items. This is likely to have impacted on the results and may have increased prevalence due to more sensitive measuring tools. In addition, children's trust in the interviewers might have increased at follow-up and children may have felt more confident in disclosing abuse.

6.7.2 Lack of validated scales

There is a general lack of standardisation across child abuse measures (Hulme, 2004), and no scales have been validated for use in South Africa. Therefore, this study used items devised from measures validated in high income countries (Briere, 1992; Finkelhor, Hamby, Ormrod, & Turner, 2005), which were piloted for cultural suitability with South African children, social

workers and staff working with orphans and vulnerable children. In addition, none of the scales used to measure risk factors had been validated in South Africa. However, all scales had been used successfully in previous studies and showed good reliability in those samples (Cluver, Fincham, & Seedat, 2009; Cluver, Kgankga, & Kuo, 2010; Cluver & Orkin, 2009; Meinck et al., 2013; Van der Merwe & Dawes, 2000; Ward, 2005). For all measures which had not been validated, scales with high psychometric properties were chosen.

6.7.3 Establishing illness with Verbal Autopsy Checklist

Less than two-thirds of South Africa's population know their HIV status, which makes self-reporting of HIV status unreliable (Peltzer, Matseke, Mzolo, & Majaja, 2009). Instead, the Verbal Autopsy Checklist was used to determine AIDS-illness. Therefore, this study was not able to identify households with asymptomatic HIV-positive members. The Verbal Autopsy has been validated in South Africa (Hosegood, Vanneste, & Timaeus, 2004), albeit with only adult populations. This study only used child report for HIV status; however, this approach has been used successfully with children in previous studies with good reliability (Boyes, Mason, & Cluver, 2013; Cluver, Bowes, & Gardner, 2010; Cluver et al., 2013; Meinck et al., 2013). A recent study investigated the concurrence of child and caregiver reporting on the Verbal Autopsy. It found high levels of concordance of symptoms and diagnosis (>70%) as well as concurrency agreement above the 60th percentile for eight out of ten symptoms (Becker, Kuo, Operario, Moshabela, & Cluver, under review).

6.7.4 Study settings

The study was carried out in randomly selected areas with >30% HIV-prevalence. These areas were sampled due to the over-arching aim of the main research project to assess the impact of HIV/AIDS on families. In addition, the vast majority of areas with high HIV-prevalence in South Africa are inhabited by black populations. All of the children in this sample were of black African background. Results of this study cannot, therefore, be generalised across the South

African child population, but they give a good indication of risks for children in low-income areas with high HIV-prevalence.

6.7.5 Unmeasured confounding

There is a strong likelihood of unmeasured confounding factors in this study, as suggested by the low values of R^2 . Most other studies on risk factors for child abuse victimisation do not report their R^2 , making comparisons difficult. Even though all regression analyses adjusted for potential confounding variables such as age, rural/urban location, province and informal housing, unmeasured confounding is still very likely. By using child report only, risk factors or confounders attributed to caregiver history or parental behaviour, apart from where experienced by the child, could not be measured reliably. Possible confounders such as parental education, parental mental health, and, in particular, parental substance use thus were not measured. Unmeasured confounding cannot be ruled out without randomisation (Ho, Peterson, & Masoudi, 2008). Future research could valuably investigate risk factors through either a randomised or matched case-control design in order to minimise unmeasured confounding.

6.7.6 Study design

The current study was a longitudinal community-based study using random household sampling techniques. Longitudinal observational designs allow for identification of correlate directionality, as the hypothesised risk factors precede the outcome. Analyses can be carried out to predict a certain outcome, such as child abuse, with hypothesised risk factors. However, observational risk factor studies cannot determine causality due to threats to internal validity. In order to determine causality, an association between risk factor and outcome has to first be established. Second, the risk factor has to precede the outcome. Third, It has to be established that only the exposure to the risk factors has led to the change in the outcome (Murray, Farrington, & Eisner, 2009). This means that one has to be able to ascertain with certainty that a change in outcome is not due to differences in the groups exposed to the risk factors and those

not exposed. Furthermore, the impacts of historical events or naturally occurring changes should be excluded (Shadish, Cook, & Campbell, 2002).

6.7.7 Inclusion of questions in questionnaire

Since this study was not originally designed to investigate risk factors for child abuse victimisation, not all hypothesised risk factors could be included in the questionnaire. Apart from caregiver-specific questions which children would not have been able to report on reliably (i.e., mental health and childhood abuse), a number of risk factors were not measured due to space constraints. No information is available regarding relationship dynamics between the child and other members of the household. Apart from information on social support, no data were collected on the relationships and networks between children and their friends or peers. Equally, caregiver education, employment type, substance use, child's relationship with step-parents and biological parents not living within the household were not measured. In addition, future research could valuably investigate cultural or societal factors such as ethnic background, religious beliefs, attitudes towards women and children, and attitudes towards corporal punishment, violence and abuse.

6.7.8 Translation

Despite ensuring careful translation, back-translation from the local languages and extensive interviewer training, translation errors cannot be discounted. Translation was carried out in five languages (Sepedi, Tsonga, Zulu, Xhosa, and Swati), and interviews were held in the language of the child's choice. Where children did not understand questions, interviewers were asked to clarify, which may have introduced interviewer bias and additional changes to the translated versions of the questionnaire.

6.8 Policy implications

This study has a number of important implications for policy and practice. First, the study highlights the high burden of physical, emotional and sexual child abuse victimisation of children in rural and urban areas with high HIV prevalence. Despite the large numbers of children who are victims of child abuse, child abuse prevention and child protection have been under-served thus far in sub-Saharan Africa. This reflects shortages in health- and social care personnel, limited resources, and weak health and social care infrastructures.

Second, child protection efforts should be extended to older children and adolescents considering the high prevalence rates of abuse amongst this group, as shown in this study. The risk for fatal child abuse may be lower in this older age group; however, emotional and sexual abuse victimisation increases. It is therefore important to acknowledge that adolescents are a very vulnerable group and should receive targeted services for protection and abuse response. Abuse of adolescents has also been identified as an under-researched and little-addressed social problem in high-income countries (Blum & Runyan, 1980).

Third, evidence was found in this study that children in families affected by AIDS and other chronic illnesses are at higher risk for physical and emotional abuse victimisation. It is therefore important to create synergies amongst child protection, HIV/AIDS, health and family support services to increase child abuse prevention efforts for this group. However, implementing child protective services with a sole focus on families affected by AIDS or chronic illness may increase stigma. This practice also does not reflect the fact that AIDS and other chronic illnesses are factors that put children at risk of abuse. A holistic, evidence-based approach to child abuse prevention and response should be used when designing and implementing interventions.

Fourth, this study showed that girls who had dropped out of school and had experienced prior victimisation were at higher risk for sexual abuse victimisation. The effect of prior assault on sexual abuse was moderated by high peer support. It is therefore important to design

interventions to keep girls in school and prevent re-victimisation. Unfortunately, the study found no risk factors for child sexual abuse in boys, and potential risk factors for boys need to be investigated further.

Finally, the study identified a number of potential intervention targets for child abuse prevention and child protection on all levels of the Ecological Framework. While factors such as gender and age are unlikely to be subject to interventions, other risk and protective factors show promise for child abuse prevention intervention design. Strengthening child protection systems and responses to abuse may prevent re-victimisation in current victims. Poverty alleviation may reduce the risk for child abuse victimisation in families by reducing income-related stress. Interventions to increase adherence to antiretrovirals may enable caregivers with AIDS to regain their physical health, prevent further poverty and reduce mental health problems in the population. Interventions such as feeding schemes, free schools and support for struggling learners may prevent vulnerable children from dropping out of school, thereby reducing the risk for sexual abuse. Family support interventions for families affected by disability and chronic illness may decrease child abuse by reducing mental distress. In addition, interventions to reduce community violence and to increase peer support may be beneficial in preventing sexual abuse. Careful testing and evaluation of interventions is needed in order to ensure appropriateness, effectiveness and sustainability.

6.9 Directions for future research

This study provided evidence on prevalence rates and risk factors for child abuse victimisation. Future research can build on this evidence and explore questions that this study was unable to answer.

First, very limited evidence is available on physical, emotional and sexual abuse victimisation in children under ten years of age. There is an emerging evidence-base on fatal incidents of child abuse (Mathews et al., 2013), but little is known about prevalence rates and risk factors

for this population. Future research could valuably focus on this age group. Second, the majority of risk factor research on sexual abuse has been carried out with girls. Yet this study showed that regularly-occurring sexual abuse appears to affect girls and boys equally. Future research should focus on risk factors for child sexual abuse victimisation of both boys and girls. Third, step-parents were found to be a risk factor for sexual abuse victimisation within the systematic review. Unfortunately, this study could not test this hypothesis. Future research should investigate the relationship between living with a step-parent and sexual abuse. Knowing what places children with step-parents at higher risk for abuse could be helpful for intervention design. It is particularly important for polygamous societies to unpack the concept of step-parenthood. Fourth, surprisingly few children reported teachers as sexual abusers or harassers. This is contrary to findings from other studies and merits further investigation. Fifth, as this study used no caregiver report at all, risk factors surrounding caregiver mental health, substance abuse and caregiver history (Black, Heyman, et al., 2001a, 2001b; Stith et al., 2009; Walsh et al., 2003) should be explored by further studies. Finally, peer social support was found to be a protective factor for sexual abuse victimisation. It was also found to moderate the risk of sexual abuse for girls who had experienced prior assault victimisation. Further research is needed to confirm the moderating effect of social support as it is likely to be relevant for targeting interventions and identifying children most at risk.

6.10 Conclusion

This is the only longitudinal community-based study on risk factors for child abuse victimisation in South Africa. It provides large-scale assessment of physical, emotional and sexual abuse victimisation in vulnerable communities affected by AIDS in South Africa. High prevalence rates of physical, emotional and sexual child abuse victimisation were found. A systematic review of studies carried out on the African continent was used to identify risk factors for child abuse victimisation at all levels of the ecological model (Belsky, 1993). Factors

from different levels of the Ecological Framework identified by the systematic review were then tested as predictive factors in this study.

The over-arching aim of this study was to help identify possible interventions to prevent child abuse. It is hoped that this research will contribute towards evidence-based policies and programmes for child protection and child abuse prevention in vulnerable populations in South Africa.

6.11 Dissemination

Findings do not become useable evidence unless one disseminates them. Thus far, the findings of this research have been presented to the World Health Organization Violence and Injury Prevention Unit, UNICEF South Africa, the NSPCC Child Protection Research Centre at the University of Edinburgh and the Office on the Rights of the Child in Mpumalanga. Future research dissemination is planned for UNICEF Child Protection in New York, UNICEF Child Protection Eastern and Southern Africa, Childline South Africa and the South African Departments of Health and Social Development. Furthermore, all articles arising from this thesis will be designed into policy briefs to facilitate understanding by non-academic audiences, and these briefs will be disseminated via social media, OVC newsletters and specific practice publications such as South African Child Gauge.

This thesis consists of four journal articles. The first article was published in *Trauma, Violence & Abuse* in March 2014. The other three journal articles are currently under review or are about to be submitted at *Child Abuse & Neglect* (Paper 2), *Journal for Interpersonal Violence* (Paper 3), and *Sexual Abuse* (Paper 4).

The findings of this thesis have also been presented at the following conferences: OVC in Africa Conference in Johannesburg (2010), International Congress for the Prevention of Child Abuse & Neglect in Istanbul (2012), European Regional Conference for Child Abuse & Neglect in

Dublin (2013), Graduate Research Student Conference in Oxford (2013), and HIV/AIDS Student Research Day in Oxford (2012). Three abstracts have been accepted for presentation at the International Congress for the Prevention of Child Abuse and Neglect in Nagoya (2014) and the International AIDS Conference in Melbourne (2014).

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7 - List of appendices

Appendix 1 Ethical Protocols: Oxford University

CUREC 1

University of Oxford

CENTRAL UNIVERSITY RESEARCH ETHICS COMMITTEE (CUREC)

IDREC Checklist

<i>*Principal investigator/supervisor/student researcher:</i>	Principal investigators: Dr Lucie Cluver (University of Oxford) Prof Frances Gardner Dr Don Operario (Brown University) Dr Mosa Moshabela (University of Witswatersrand) Prof Andy Dawes (HSRC) Dr Lauren Wild (University of Cape Town) Students: Marisa Casale (University of KwaZulu Natal) Caroline Kuo (University of Oxford) Tyler Lane (University of Oxford) Kerry Mauchline (University of Oxford)
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<u>FOR STUDENT RESEARCH PROJECTS ONLY</u>	
<i>Name of Supervisor:</i>	
<i>Department or institute:</i>	Department of Social Policy and Social Work
<i>Address for correspondence:</i>	Department of Social Policy and Social Work Barnett House 32 Wellington Square Oxford, OX1 2ER
<i>E-mail and telephone contact:</i>	<u>lucie.cluver@socres.ox.ac.uk</u> +44(0)1865280370

Before completing this checklist, please ensure you have consulted the following CUREC guidance documents available on the CUREC website at <http://www.admin.ox.ac.uk/curec/resrchapp/index.shtml>:

Guidance on approval process

Glossary

FAQs

This checklist is the first stage of the University of Oxford's scrutiny procedure for *research involving *human participants. (Definitions of terms marked with an asterisk are to be found in CUREC's glossary and guidance).

The University aims to ensure that all research is subject to *appropriate* ethical scrutiny. This form is designed to identify those projects which fall outside CUREC's remit; those which fall within CUREC's remit but which pose low risks to participants and so need scrutiny only through this checklist; and those which fall within CUREC's remit and which pose greater risk to participants and so need more scrutiny. If you need further advice or if you have comments about this form, please consult the relevant IDREC officer (please see: <http://www.admin.ox.ac.uk/curec/oxonly/contact.shtml>).

The checklist should be completed by the *principal investigator/supervisor/student researcher (under the guidance of his/her supervisor) undertaking or supervising research which comes under CUREC's responsibility. Please carry out a risk assessment of the project, in consultation with all researchers involved, using the checklist and CUREC's other documentation.

This form does not cover research governance, satisfactory methodology, or the health and safety of employees and students. As principal investigator, it is your responsibility to ensure that requirements in these areas are met.

Office use only:

IDREC Ref. No. _____

Date of confirmation that checklist accepted on behalf of IDREC: // //

Section A

*Title and brief lay description of *research (about 150 words), plus description (about 200 words) of the nature of participants (including the criteria for inclusion/exclusion, method of recruitment, attaching samples of participant information and consent forms), purpose of the research, methods to be used, and use to which the results/data will be put.*

Title: Young Carers for AIDS-ill family members in South Africa: Predictors for providing care and psychological, health, and educational outcomes

Brief description of research:

The Centre for Evidence-Based Intervention at Oxford University and the Directorate of HIV/AIDS at the Ministry of Social Development (Government of South Africa) have identified a need for high-quality quantitative research on health, educational, and social outcomes for young carers of HIV and AIDS-unwell adults in southern Africa.

Children living with AIDS-unwell and other-unwell caregivers in sub-Saharan Africa often undertake medical, intimate, and emotional care, as well as domestic responsibilities (Bauman et al., 2006; Evans & Becker, 2007; Robson, 2000). Despite this, only one study exists that quantitatively compare carers to non-carers ($n = 60$) (Gwandure, 2007). The results suggested that children who provide care for their parents suffer from poorer psychological outcomes than non-caring peers, and have poorer learning ability. Unfortunately like many studies of Young Carers, participants were operationally defined. There is a need to see how carers differ from non-carers in the amounts of tasks they are doing (both caring and domestic tasks), and how children living with an ill person differ from each other based on demographic characteristics. This will then allow us to accurately assess how children become carers, how carers differ from other children in health, educational, and social outcomes, their needs, and risk and protective factors.

The research follows a qualitative study carried out in the Western Cape Province from September to December, 2008. This received ethical approval from the DREC and IDREC at Oxford, and from the University of Cape Town. It will consist of cross-sectional and longitudinal quantitative interviews asking children about the types of tasks they take on and time devoted to them, standardised questionnaires regarding physical health, mental health, social and

educational outcomes, risk and protective factors, and caregiver illness and symptoms. HIV/AIDS illness will be identified using a validated verbal autopsy (VA) (Lopman et al., 2006).

We will recruit children and caregivers using stratified systematic random sampling of South African Census EAs. In each EA, Geographic Information System (GIS) mapping will produce random routes (densely populated informal areas are unsuitable for traditional street-based sequential sampling). This is the same methodology developed for SA Census collection in rural and urban areas (Stoker, 1987).

We aim to conduct face-to-face interviews with 6000 children aged 10-18 from four South African provinces (KwaZulu-Natal, Gauteng, Mpumalanga, and the Western Cape). In the first year the interviews will be for cross-sectional analyses, and in the second we will have follow-ups for longitudinal analysis. In KwaZulu-Natal, children's primary caregiver(s) will also be interviewed ($n = 1500$). All interviews will be conducted by trained community health workers in the child and caregiver's language of choice. Our goal is to interview 750 children in each rural and urban enumeration area (EA) for the four provinces. This will allow us sufficient numbers for subgroup analysis, which will give us statistical power in testing our hypotheses. The subgroups will consist of categorisations such as 'child living with unwell person,' 'child not living with unwell person,' 'child living with AIDS-unwell person,' etc.

Cross sectional analyses will compare group and demographic differences on the types of tasks being performed, amount of time devoted to them, and psychological, social, health, and education outcomes. Longitudinal data collection, which will be conducted in the second year of this study, will permit us to make some inferences about causal relationships linking underlying processes related to outcomes, and to identify risk and protective factors.

<i>List all *sites where project will be conducted:</i>	Urban and rural areas of the KwaZulu-Natal, Gauteng, Mpumalanga, and Western Cape Provinces, South Africa
<i>Anticipated duration of project:</i>	<u> 3 </u> years
<i>Anticipated start date:</i>	30 / August / 2009
<i>Anticipated end date:</i>	30 / August / 2012
<i>Name and status (e.g. 3rd year undergraduate; post-doctoral research assistant) of others taking part in the project:</i>	Eight research assistants and two data enterers per site (unknown as of yet)

Section B

(Please put a tick in the yes/no column as appropriate to indicate your response).

1). Does your study primarily aim to monitor and/or improve the performance of a particular service provider?	YES	NO
		X
2) Will your conclusions be applicable wholly or primarily to that service provider?	YES	NO
		X

3) <i>Are you conducting your study on behalf of or at the request of a service provider?</i>	YES	NO
		X

If you have answered 'yes' to any question in section B it is likely that your study is *audit, not *research. Please check CUREC glossary and if your study is audit you need not submit your proposal for ethical scrutiny. If you have answered 'no' to all questions please proceed to section C.

Section C

(Please put a tick in the yes/no column as appropriate to indicate your response).

1) Will the research involve <i>*human participants recruited by means of their status</i> <i>as present or past NHS *patients or their relatives or carers or present or past NHS staff?</i>	YES	NO
		X
2) Will the research involve <i>*personal data of any of the people listed in question C</i> <i>1 above ?</i>	YES	NO
		X
3) Will the research in whole or part be carried out on NHS premises or using <i>NHS facilities?</i>	YES	NO
		X
4) Does the research involve administering any drug, placebo, or other <i>substances</i> <i>to participants in the European Union (EU)?</i>	YES	NO
		X
5) Does the research involve ionising radiation in the EU?	YES	NO
		NO

		X
6) Does the research involve human genetic research in the EU?	YES	NO
		X
7) Does the research involve magnetic resonance imaging in the EU?	YES	NO
		X
8) Does the research involve use of organs or other bodily material of past and present NHS patients?	YES	NO
		X
9) Does the research involve any other *invasive procedure (Class A) not described above?	YES	NO
		X
10) Does the research involve *human participants aged 16 and over who do not have *capacity to consent for themselves?	YES	NO
[Please note that the definition of *capacity has been altered by the Mental Capacity Act 2005; see the <u>Glossary</u> on the CUREC website for further information]		X

If you have answered 'yes' to any question in section C please stop work on this checklist as you will need to submit your proposal to the appropriate NHS ethics committee. Further details may be obtained from the website <http://www.nres.npsa.nhs.uk>. Please submit the NHS Ethics Committee approval to the relevant IDREC officer for information when received.

If your research involves any of the above procedures but will be carried out by University of Oxford staff wholly outside the EU your research will be scrutinised by OXTREC (<http://www.tropicalmedicine.ox.ac.uk/oxtrecframeset.htm>). If you have answered 'no' to all questions so far, please proceed to section D.

Section D

(Please put a tick in the yes/no column as appropriate to indicate your response).

1) <i>Is the study to be funded by the US National Institutes of Health or another US federal funding agency?</i>	YES	NO
		X

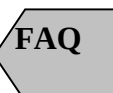
If you have answered 'yes' to the question in section D please stop work on this checklist as you will need to submit your proposal to OXTREC which uses separate documentation (<http://www.tropicalmedicine.ox.ac.uk/oxtrecframeset.htm>).

If you have answered 'no' to all questions so far, please proceed to section E.

Section E

(Please put a tick in the yes/no column as appropriate to indicate your response).

1) <i>Are all the data about people to be used in your study previously collected anonymised data which neither you nor anyone else involved in your study can trace back to the individuals who provided them (e.g. census data, administrative data, secondary analysis)? Please refer to the definition of *personal data in the glossary and FAQ no. 6 for further guidance.</i>	YES	NO
		X



If you have answered 'yes' to the question in section E please stop work on this checklist as you do not need to secure ethical approval for your study. There is no need to submit any details to IDREC as such research does not constitute research involving human participants for review purposes.

If you have answered 'no' to all questions so far, please proceed to section F.

Section F

Methods to be used in the study (tick as many as apply: this information will help the committee understand the nature of your research and may be used for audit).

METHOD USED	PLEASE
<i>Unstructured interview</i>	
<i>Semi-structured interview</i>	
<i>Structured interview</i>	X
<i>Questionnaire</i>	X
<i>Analysis of existing records</i>	
<i>Participant performs verbal/paper and pencil/computer based task</i>	
<i>Measurement/recording of motor behaviour</i>	
<i>Audio recording of participant</i>	
<i>Video recording or photography of participant</i>	
<i>Physiological recording from participant</i>	
<i>Participant observation</i>	
<i>Systematic observation</i>	
<i>Observation of specific organisational practices</i>	
<i>Other (please specify)</i>	

Section G

(Please put a tick in the yes/no column as appropriate to indicate your response).

1). Have you made arrangements to obtain written *informed consent from participants?	YES	NO
	X	

2) Have you made arrangements to ensure that <i>*personal data collected from participants will be held in compliance with the requirements of the Data Protection Act?</i>	YES	NO
	X	
3) If your research involves any use of <i>*personal data obtained from a *third party, have you checked to ensure that the *third party has arrangements in place to permit disclosure?</i>	YES	NO
	X	
4) Does the research involve as participants <i>*people whose ability to give free and informed consent is in question?</i>	YES	NO
	X	
5) Does the research involve any alteration of participants' normal patterns of sleeping, eating, or drinking?	YES	NO
		X
6) Is there a significant risk that the research will expose participants to visual,	YES	NO
		X

<i>auditory, or other environmental stimuli of a level or type that could have short- or long-term harmful physical effects?</i>		
7) <i>Is there a significant risk that that the research will induce anxiety, stress or</i>	YES	NO
<i>other harmful psychological states in participants that might persist beyond the duration of the test/interview?</i>		X
8) <i>Does the research involve exposing participants to any physical or</i>	YES	NO
<i>psychological hazard, beyond those of their usual everyday life, not covered by questions 9 and 10?</i>		X
9) <i>Does the research involve any *invasive procedure (Class B)?</i>	YES	NO
		X
10) <i>Will the research elicit information from participants that might render them</i>	YES	NO
<i>liable to criminal proceedings (e.g. information on drug abuse or child abuse)?</i>		X
Please see detailed notes in CUREC/2 regarding reporting of child abuse in South African context.		

11) Does the research involve the *deception of participants?	YES	NO
		X
12) Will the research require a participant to spend more than 2 hours in any single session on activities designed by the researcher (NB this time restriction does not refer to situations where participants are observed going about activities not devised by the researchers e.g. observation of lessons in schools)?	YES	NO
		X
13) Will the research involve a significant risk of any harm of any kind to any participant not covered above?	YES	NO
		X
14) Do you intend to follow any professional/CUREC guidelines (please provide details)	YES	NO
	X	
The proposed ethical guidelines for this study are informed by a number of sources. These include the ethical requirements of the South African Department of Health, and ethical guidelines from research bodies such as the British Psychological Society (1992) and the Social Research Association (2002). South African sources included the Policy Guidelines for Course of Conduct, Code of Ethics, the Rules for Social Workers of the South African		

Council for Social Services Professions, and Department of Health's Ethics
in Health Research (DOH, 2004).

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If any of your answers in section G are in a shaded box, please complete section H. If all your answers in section G are in the unshaded boxes, please complete section I.

Section H

FAQs

One or more aspect(s) of your research project suggest(s) that it may pose risks to participants (see shaded box(es) ticked in section G).

<i>Are all the aspects of your project which caused you to tick a shaded box in section F fully covered by research protocol(s) which has/ve received IDREC/CUREC approval?</i>	YES	NO
	Please give IDREC protocol number (s). Please proceed to section I.	Please complete this form AND form CUREC/2 and submit both to the relevant Inter Divisional Research Ethics Committee.
<i>If you answered NO to question 1) in Section G concerning informed consent but a section of the Code of Practice governing your research activity is relevant, are you going to apply the standard set out in the Code of Practice?</i>	Name of Code of Practice and section number: Please proceed to section I.	Please complete this form AND form CUREC/2 and submit both to the relevant Inter Divisional Research Ethics Committee.

FAQ

Section I

FAQs

Complete this section only if you do not need to submit form CUREC/2.

I understand my responsibilities as principal researcher/supervisor/student researcher as outlined on p.1 of this form and in the CUREC glossary and guidance.

I declare that the answers above accurately describe my research as presently designed and that

I will submit a new checklist should the design of my research change in a way which would alter any of the above responses so as to require completion of CUREC 2/full scrutiny by an IDREC. I will inform the relevant IDREC if I cease to be the principal researcher on this project and supply the name and contact details of my successor if appropriate.

FAQs

Signed by principal researcher/supervisor/student researcher:.....
.....

Date:.....

Print name (block capitals).....

Signed by supervisor:.....(for student projects)

Date:.....

Print name (block capitals).....

I understand the questions and answers that have been entered above describing the research, and I will ensure that my practice in this research complies with these answers.

Signed _____ by _____ associate/other _____ researcher:
.....

Print _____ name _____ (block
capitals).....

Date

I have read the research project application named above. On the basis of the information available to me, I:

(i) consider the principal researcher/supervisor/student researcher to be aware of her/his ethical responsibilities in regard to this research;

(ii) consider that any ethical issues raised have been satisfactorily resolved or are covered by CUREC approved protocols, and that it is appropriate for the research to proceed without further formal ethical scrutiny at this stage (noting the principal researcher's obligation to report should the design of the research change in a way which would alter any of the above responses);

(iii) am satisfied that the proposed project has been/will be subject to appropriate *peer review and is likely to contribute something useful to existing knowledge and/or to the education and training of the researcher(s) and that it is in the *public interest.

(iv) [FOR DEPARTMENTS/FACULTIES WITH A DEPARTMENTAL RESEARCH ETHICS COMMITTEE (DREC) OR EQUIVALENT BODY - PLEASE DELETE IF NOT APPLICABLE] confirm that this checklist (and associated research outline) has been reviewed by the Department's Research Ethics Committee (DREC)/equivalent body, and attach the associated report from that body.

Signed:.....(Head of department or nominee e.g Chair of
DREC, Director of Graduate Studies for student projects)

Print name (block
capitals).....

Date:.....

Please send an electronic copy and a signed paper copy of this completed checklist to whichever
of the IDRECs is more suitable (Social Sciences or Medical Sciences) keeping a copy for
yourself.

IDRECs and/or CUREC will review a sample of completed checklists and may ask for further
details of any project.

Revised July 2008

CUREC 2

University of Oxford

CENTRAL UNIVERSITY RESEARCH ETHICS COMMITTEE (CUREC)

Not all research project leaders need to fill in this form. Before starting work on this form, please fill in CUREC's checklist (CUREC/1) which will show if you need to complete this form. Please also ensure you have consulted the following CUREC guidance documents available on the CUREC website (<http://www.admin.ox.ac.uk/curec/resrchapp/index.shtml>):

FAQs

Guidance on approval process

Glossary

FAQs

Definitions of terms marked with an asterisk are to be found in CUREC's glossary and guidance.

SECTION 1: PROJECT TITLE, RESEARCHERS, AND CONTACT DETAILS

1. Person to whom IDREC/CUREC should direct correspondence.

*Principal investigator/supervisor/student researcher

Title and name: Dr Lucie Cluver

Appointment: University lecturer

Department: Department of Social Policy and Social Work

Institution: University of Oxford

Address:

FAQ

Department of Social Policy and Social Work

Barnett House

32 Wellington Square

Oxford, OX1 2ER

Phone: +44 1865 270325

Fax: +44 1865 270324

e-mail: lucie.cluver@socres.ox.ac.uk

Will you need training to participate in this project?

☐ Yes ☒ No

FOR STUDENT RESEARCH PROJECTS ONLY

Name of Supervisor:

2. Full project title and proposed starting date:

Title: Young Carers for AIDS-ill family members in South Africa: Predictors for providing care and psychological, health, and educational outcomes

Starting Date: 30 August 2009

FAQs

Office use only:

IDREC Ref. No. _____

Date of Approval: / /

Application date: / /

Approval Period: from / / to / /

Signature of IDREC approver: _____

Name (printed) and position of approver: _____

Date applicant informed of approval: / /

3. Are you submitting this project to another ethics committee or has it been previously submitted to an ethics committee?

☒ Yes - provide details.

☐ No

University of KwaZulu-Natal Research Ethics Committee

University of Cape Town Health Sciences Research Ethics Committee

University of Witwatersrand Public Health Research Ethics Committee

Mpumalanga Provincial Research Ethics Committee

Provincial Health Research Ethics Committees if established in Western Cape, Gauteng, Kwa-Zulu Natal (not yet in operation)

We have discussed this application with all the committees 1-4 mentioned above, and with the Director of Health RECs at the National Department of Health, and all have requested that we submit to them subsequent to obtaining approval from Oxford University.

If other relevant approvals for this research are required (e.g. from other universities' ethics committees) please attach them.

4. Have you made use of professional/CUREC guidelines in framing your research project and preparing documentation?

Note: the CUREC guidelines are available online (<http://www.admin.ox.ac.uk/curec/oxonly/protocols/guidelines.shtml>) or by emailing curec@admin.ox.ac.uk

☒ Yes - provide details.

☐ No – explain why not.

We have made sure to use the CUREC guidelines in framing our research project and preparing documentation with regards to recruitment, training and administration of interviews, responding to participants experiencing acute distress, and recording details and making referrals in case of serious incidents. The consent forms we provide clarify the purposes of this study, in addition to the nature of the research to be conducted and explicit statements regarding participants' rights to opt-out at any point. Given that this study is taking place in South Africa, we have additionally used a number of other sources for guidelines, such as South African legislation, and these are detailed below.

5. Researchers involved in this project

Please supply one completed copy of this box for each researcher.

For each researcher who requires training to participate in this project, describe training on a separate page and include the name of the trainer(s).

*Associate researcher/student researcher
Title and name: Professor Frances Gardner
Appointment: Professor
Department: Social Policy and Social Work
Institution: University of Oxford

Address:	
Department of Social Policy and Social Work	
32 Wellington Square	
Oxford OX1 2ER	
Phone: +44 (0) 1865 270334	Fax:
e-mail: frances.gardner@socres.ox.ac.uk	
Role	in this project: co-PI
Qualifications and relevant experience for this project: DPhil; MPhil Clinical Psychology; supervisor of earlier project	
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

*Associate researcher/student researcher
Title and name: Professor Don Operario
Appointment: Associate Professor of Community Health
Department: Community Health
Institution: Brown University
Address:
Providence
Rhode Island

USA	
Phone: +1 401 863 6557	Fax:
e-mail: don_operario@brown.edu	
Role	in this project: co-PI
Qualifications and relevant experience for this project: PhD (Psychology) Primary investigator on previous AIDS-affected children studies	
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

*Associate researcher/student researcher
Title and name: Dr Mosa Moshabela
Appointment: Senior Lecturer, School of Public Health, University of Witwatersrand Director, University of Witwatersrand Rural AIDS and Development Action Research Programme
Department: School of Public Health
Institution: University of Witwatersrand
Address: Tintswalo District Hospital Acornhoek, Mpumalanga South Africa Telephone: +27 13 795 5076 Fax: +27 13 795 5082
e-mail: mosa@agincourt.co.za ?

Role	in	this	project:	co-PI
Qualifications and relevant experience for this project: MD, MMED, Clinical Director of provincial HIV programme, specialist in HIV-TB infection				
Will this researcher need training to participate in this project? ☐ Yes ☒ No				

*Associate researcher/student researcher
Title and name: Professor Andy Dawes
Appointment: Professor
Department: Department of Psychology
Institution: University of Cape Town
Address: Department of Psychology, University of Cape Town Private Bag, Rondebosch, 7700 South Africa Tel +27-21-683 5199; Fax +27-21-683 5199
e-mail: adkinloch1@gmail.com
Role in this project: Co-I
Qualifications and relevant experience for this project: MSc, has run multiple major studies on children and child abuse in South Africa
Will this researcher need training to participate in this project? ☐ Yes ☒ No

*Associate researcher/student researcher				
Title and name: Dr Lauren Wild				
Appointment: Senior Lecturer				
Department: Department of Psychology				
Institution: University of Cape Town				
Address: Department of Psychology, University of Cape Town				
Private Bag, Rondebosch, 7700 South Africa				
Phone: +27-21-6504607; Fax: +27-21-6504104				
e-mail: Lauren.Wild@uct.ac.za				
Qualifications and relevant experience for this project: PhD, Clin Psych, PI on prior studies of AIDS-affected children in South Africa				
Role	in	this	project:	co-I
Will this researcher need training to participate in this project? ☐ Yes ☒ No				

*Associate researcher/student researcher				
Title and name: Marisa Casale				
Appointment: Senior Researcher				
Department: Health Economics and AIDS Research Division (HEARD)				

Institution: University of KwaZulu-Natal
Address: HEARD University of Kwa-Zulu Natal, Durban Westville Campus
e-mail: <u>casale@ukzn.ac.za</u>
Role in this project: Student researcher Qualifications and relevant experience for this project: Extensive experience of project managing research with children in Durban area Degree course (if relevant): PhD Will this researcher be approved by the principal researcher as competent to obtain *informed consent from participants? YES
Will this researcher need training to participate in this project? ☐ Yes ☒ No

*Associate researcher/student researcher
Title and name: Caroline Kuo
Appointment: DPhil Candidate, Evidence-Based Social Intervention
Department: Social Policy and Social Work
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32 Wellington Square	
Oxford, OX1 2ER	
Phone: +44 (0) 1865 270325	Fax: +44 (0) 1865 270324
e-mail: caroline.kuo@nuffield.ox.ac.uk	
Role in this project:	Student researcher
Qualifications and relevant experience for this project: Previous experience with researching AIDS-affected families in South Africa	
Degree course (if relevant): DPhil	
Will this researcher be approved by the principal researcher as competent to obtain *informed consent from participants? YES	
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

*Associate researcher/student researcher
Title and name: Tyler Lane
Appointment: DPhil Candidate, Evidence-Based Social Intervention
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Institution: University of Oxford
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Oxford, OX1 2ER	
Phone: +44 (0) 1865 270325	Fax: +44 (0) 1865 270324
e-mail: tyler.lane@socres.ox.ac.uk	
Role in this project: Student research	
Qualifications and relevant experience for this project: Research coordinator on qualitative Young Carer study in Western Cape	
Degree course (if relevant): DPhil	
Will this researcher be approved by the principal researcher as competent to obtain *informed consent from participants? YES	
Will this researcher need training to participate in this project? ☐ Yes ☒ No	

*Associate researcher/student researcher
Title and name: Kerry Mauchline
Appointment: DPhil Candidate
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e-mail:	kerry.mauchline@socres.ox.ac.uk	
Role	in	this project: Student researcher
Qualifications and relevant experience for this project: Previous work on Young Carer study, coordinator of Teen Advisory Group weekend		
Degree course (if relevant): DPhil		
Will this researcher be approved by the principal researcher as competent to obtain *informed consent from participants? YES		
Will this researcher need training to participate in this project? ☐ Yes ☒ No		

SECTION 2: PROJECT DESCRIPTION

6. Description of project

Please give a description (300-800 words) of your project to supplement the information already provided in Section A of the checklist (CUREC/1), detailing those aspects of the project which involve *human participants, particularly any aspect which is beyond already established and accepted techniques. Please attach all other documents (e.g. questionnaire, recruitment advertisements, participant information, and consent forms) that you plan to use in the study. Please note that detailed scientific background is not required unless directly relevant to ethical issues.

Please see project details on www.youngcarers.net.au.net

The Centre for Evidence-Based Intervention at Oxford University, in collaboration with the Government of South Africa (Directorate of HIV/AIDS at the Ministry of Social Development, the Sector of Maternal and Child Health at the Department of Health, and the Directorate of Health in Education at the Department of Education) have identified a need for high-quality qualitative and quantitative research on health outcomes for Young Carers of AIDS-unwell adults in southern Africa.

The study has been devised with the input of the South African government departments (above) and with the National Action Committee for Children Affected by AIDS (NACCA). We have also consulted extensively with local and international NGOs, service providers such as social workers, nurses and medics, and with HIV-affected groups of children and at the South African AIDS Conference 2009.

Children living with AIDS-unwell and other unwell family members in sub-Saharan Africa often undertake medical, intimate, and emotional care tasks, as well as domestic responsibilities (Bauman et al., 2006; Evans & Becker, 2007; Robson, 2000). Despite this, there is only one study from sub-Saharan Africa that quantitatively compares carers to non-carers ($n = 60$) (Gwandure, 2007). The results suggested that children who provide care for their parents suffer from poorer psychological outcomes than non-caring peers, and display poorer learning ability. Firstly, there is a need to see how young carers differ from non-carers in the amount of tasks they are carrying out (both caring and domestic), and how children living with an ill person differ from each other based on demographic characteristics. This will then allow us to accurately assess predictors for providing care. Secondly, there is a need to identify whether Young Carers experience negative outcomes in terms of health, education and social development. Thirdly, it is important to identify the causal mechanisms of such

negative outcomes, in order to inform the design of interventions (thus requiring a longitudinal design).

This research follows a qualitative study carried out in the Western Cape Province from September to December, 2008, which was approved by DREC, IDREC at Oxford, and the Health Sciences REC at the University of Cape Town. In the qualitative study, 548 children were interviewed in urban and rural areas. Children self-identified as living with someone who was unwell, then agreed to participate after receiving informed consent. Of the 548, five interviews were terminated before completion upon participant request.

The longitudinal quantitative study which is the subject of the current application will be interviewing children in four provinces (Gauteng, KwaZulu-Natal, Mpumalanga, and the Western Cape), and their caregivers in one (KwaZulu-Natal). We aim to conduct face-to-face interviews with 6000 children aged 10-18, and around 1500 face-to-face interviews with caregivers. For all participants, interviewers will first read information sheets and obtain informed consent from both child and primary caregiver. Interview booklets are structured and presented in the style of a teen magazine quiz. This is the result of a suggestion of a group of teens in our Teen Advisory Group, who helped guide our qualitative study.

(NB The 'Teen Advisory Group' are a group of 12 AIDS-affected children who advise the project on questionnaire design and content. This was approved by Oxford DREC in 2008)

Interview booklets will include standardised questionnaires regarding physical health, mental health, educational and social outcomes, risk and protective factors for Young Carers, and caregiver illness and symptoms. We are aware of the stigma surrounding HIV/AIDS in sub-Saharan Africa, and are therefore using a validated Verbal Autopsy (VA) (Lopman et al., 2006). Though many children in our previous study were willing to disclose a parent's AIDS-illness, we want to ensure that there is no unintentional disclosure. This will also allow us to

identify AIDS-illness when parents have declined to disclose status to their children for fear of stigma or upsetting them. Under no circumstances will we disclose possible AIDS-morbidity or mortality to the child or anyone else.

We will recruit participants using stratified systematic random sampling of South African census Enumeration Areas (EAs). Within each EA, Geographic Information System (GIS) mapping will produce random routes that determine which households will be approached for participation in a methodology developed for South African Census collection in rural and urban areas (Stoker, 1987). This will ensure that sampling was randomised throughout rural and urban areas, as densely populated urban areas are unsuitable for traditional street-based sequential sampling.

7. Literature search

If the research involves significant risk to the human participants please describe what literature searches have been undertaken to obtain information to aid risk reduction/management.

There is an extensive body of work, both in the UK and South Africa, on ethical concerns in research with ‘vulnerable’ children and young people. The proposed ethical guidelines for this study are informed by a number of sources. These include the ongoing academic debate on issues such as informed consent and confidentiality (Alderson & Morrow, 2004), the ethical requirements of the universities and research institutions involved in designing the research, and ethical guidelines from psychological research bodies such as the British Psychological Society (BPS, 2006).

Furthermore, key research guidelines and legislation in South Africa have been considered, including the Department of Health, Research Ethics Guidelines 2004, the Department of Health, Guidelines for Good Clinical Practice in South Africa, 2nd Edition 2006, the National

Health Act 61 of 2003, the Children's Act 38 of 2005, the Children's Amendment Act 41 of 2007 and the Sexual Offences Act 32 of 2007.

SECTION 3: RESEARCH INVOLVING CONTACT WITH *HUMAN PARTICIPANTS

If the project does NOT involve contact with*human participants, but only use of data about them, do NOT complete this section, but go to Section 4. If you are not completing Section 3 please delete it from your application to save paper.

8. Description of participants

How many participants will be involved in the project?

7500 participants (6000 aged 8-18, 1500 adult caregivers)

-750 children from rural and urban areas in each province

-4 provinces (Gauteng, KwaZulu-Natal, Mpumalanga, Western Cape)

-Caregivers of children in KwaZulu-Natal (~1500)

9. Details of participants

(a) What types of people will be recruited e.g. students,* children, people with learning disabilities? [Please see the Glossary on the CUREC website for information on how the meaning of *capacity to consent has been altered by the Mental Capacity Act 2005]

We will be interviewing children aged 8-18 in four provinces, and in KwaZulu-Natal we will interview both children and their caregivers. We will interview any age-eligible residents of any household that is selected by our random route mapping.

(b) What will be the age range of participants?

The children we will be interviewing will be between the ages of 8 and 18 years. We will also interview children's caregivers in KwaZulu-Natal, who will mostly be adults, though there is the possibility that a child's primary caregiver is a sibling under the age of 18.

(c) How will the competence of participants to give *informed consent be determined?

We will obtain informed consent from each participant in this study.

1) Consent for children to participate

In order to ensure fully informed consent for child participants, all children will be provided with information sheets describing the study in their first chosen language, which interviewers will explain. All explanations will be easily understandable for children in this study, and the child's right to decline participation and to withdraw at any time will be thoroughly explained. Only after the purpose of the study and the format of the interview have been explained will children be asked for their consent to participate.

2) Caregiver consent for child participation

Each child's caregiver will also provide consent for participation in this study, and will be provided with information describing the study in their first chosen language. In some circumstances, the child may wish to participate but the primary caregiver is unavailable, or too unwell to be able to give consent, and here the child can nominate another adult whom they trust in his or her place (such as an aunt, or social worker). These circumstances include children in child-headed households, children whose primary caregiver is not co-resident (ie is a migrant worker), and children whose primary caregiver is experiencing AIDS-related dementia.

In our prior qualitative work with Young Carers, we identified a very small but worrying group of orphaned children who wanted to participate in the study but who explained to us

that they lived with a foster carer who was forcing them to undertake large amounts of domestic work against their will, and that the carer would not want the research to take place in case this was revealed. When consent was requested from the caregiver, they did refuse. Under the provisions of our previous REC approval, we did not interview these children. However, we are extremely concerned that this resulted in a sample which was biased against some of the most disadvantaged children who we are aiming to understand.

We engaged in extensive discussion regarding this issue with colleagues at the University of Cape Town Health Sciences REC, at the University of Witwatersrand, and with Social Workers at Cape Town Child Welfare. We also consulted South African legislation, particularly the Department of Health Research Ethics Guidelines, 2004. These allow for unassisted consent for adolescents (adolescence is not defined) in the following circumstances: i) that the research contains no more than minimal risk to the child, ii) that the nature of the research is acceptable to the research ethics committee and to the community at large, iii) that the inclusion of adolescents in the study is justified, and iv) that the unassisted consent is justified. This has been used previously for studies where parents or caregivers would be unlikely to consent to adolescent participation, or where children do not want their caregiver to know they are participating, such as studies examining contraception use amongst sexually active adolescents.

We thus propose the following, and welcome further discussion on the issue: For adolescent children only (using the WHO definition of adolescence: 10-19 yrs), where the child specifically, and unprompted, states that their caregiver will not consent due to exploitative treatment of the child, we will ask the child to identify another trusted adult who would be able to give consent for the child to participate. (We would, of course, subsequently make social services referrals for all children in abusive situations – see below). As a research team, it is clear that we would *not* take advantage of this concession in order to sidestep caregiver

consent where this is inconvenient – and it would be used only for this specific and small subset of children.

Further guidelines consulted on this issue include South Africa's Children's Act 2005, which allows for minors under 18 to participate in research if there is a therapeutic effect for them (DOH, 2004). Many of the children in our qualitative study expressed gratitude and thanks for the opportunity to express themselves and talk about living with an ill person. The British Psychological Society (BPS, 2006) suggests that where children are under 16 years of age, consent should be obtained from someone *in loco parentis*, but where that is not possible, the study should be taken through ethics committee approval. This recognises various issues in gaining adult consent, such as competency of children to consent as varying with age (What in UK case law is called 'Gillick competency' and is reflected in the South African Children's Act), and the potential for situations in which parental consent may not be appropriate or possible.

Any child who declines to participate before or after the interviewer has explained the project will not be interviewed, even if the caregiver or nominated adult agrees to or encourages participation.

3) Informed consent for adult caregivers

In one province, KwaZulu-Natal, we will be interviewing children's caregivers. This study will obtain informed consent for each adult caregiver. All adults will fill in 'opt-in' consent forms if they agree to participate. All information sheets, consent forms, and interview materials will be translated into participants' first language.

4) In cases of child-headed households

Where the primary caregiver in a family is a child (a very small subgroup of homes), the head of the child-headed household will be asked if they wish to participate in the child

questionnaire. Whilst this does not provide as much information regarding household dynamics etc as the adult caregiver questionnaire, we do not consider the adult survey to be an appropriate or fun format for children.

Copies of all information sheets, consent forms and interview materials are attached.

(d) What are the *defining criteria for participation in the study?

This study aims to increase understanding of children who care for ill relatives, particularly in comparison with children who do not provide care. Therefore, all children and caregivers will be considered for inclusion in this study if they are black African and their homes appear on one of the GIS mapping routes. With studies in Soweto finding an ill adult in 44% of households (Gray et al., 2006), we are likely to get sufficient numbers of participants for each sub-group.

10. Recruitment of participants

(a) Describe how, where, and by whom participants will be identified, approached, and recruited.

We will identify households using stratified systematic random sampling of South African Enumeration Areas (EAs). Geographic Information System (GIS) mapping will produce random routes, using the same methodology developed for South African Census collection in rural and urban areas (Stoker, 1987). Other methods of recruitment have proved insufficient, such as traditional street-based sequential sampling, which does not work in densely populated informal areas, and Modified Respondent Driven Sampling (RDS), which we tried in our previous study. RDS had been designed for hidden at-risk groups, such as injection drug users (IDUs) or sex workers (Heckathorn, 1997). What we found was that as a

'hidden group' (Robson, 2004), Young Carers are also hidden from each other; the more involved they are with caring, the less likely they are to know other carers.

After identifying households, our interviewers will approach household members and ask if there are any children between 8 and 18 years of age. If there are (and their caregivers in KwaZulu-Natal), interviewers will give a brief description of the research. After they have been read the information sheets and been given an opportunity to ask questions, participants can decide if they want to participate in the research.

All recruitment will take place in Gauteng, KwaZulu-Natal, Mpumalanga, and the Western Cape.

- (b) If your research involves any use of *personal data obtained from a *third party, describe the steps you have taken to ensure that the *third party has arrangements in place to permit disclosure.

N/A

- (c) Will any *unequal relationships exist between anyone involved in the recruitment and the potential participants?

☒ Yes

☐ No

If yes:

- (i) Describe the nature of the unequal relationship.

We will be interviewing children as young as 8 years old, and as the interviewers are adults there exists an unequal age relationship. In addition, some of the children in this study will be affected by or infected with HIV/AIDS. Our qualitative study indicated many young carer

children are devoting much of their time to providing care due to household illness, and as a result may not be attending school. For these groups there may be delays or difficulties in education, with which comes the potential for decreased understanding of the methods and needs of research. Even without these difficulties, many children may be literate, semi-literate, or literate in a language other than their first language.

There is also the unequal relationship that may exist between researchers and HIV+ adults. The adults who are ill enough with AIDS to require care from their children present us a group who may be experiencing depression or whose mental capacity may be affected by advanced stages of illness.

It is crucial that while recognising these inequalities, we make all attempts to reduce their impacts on children and adult participants. However, it is also important to recognise that in a positive and child-centred research environment, children and adults can benefit from the opportunity to interact with adult facilitators.

(ii) Explain how ethical problems arising from the unequal relationship will be resolved.

All attempts will be made to ensure that the research is a positive and participatory experience for all participants, and that all consent is both voluntary and informed. All interviewers will have experience in working with vulnerable children and with AIDS-affected families.

To ensure that children do not feel obliged to participate in the research, emphasis will be placed on their ability to refuse to participate, or to cease participation at any point during the research (*See attached Draft consent and information sheets*).

Following British Psychological Society Guidelines (2006), any avoidance by children of the interview situation will be taken as evidence of failure to consent. Children who refuse to participate, or who stop the interview, will still receive snacks and certificates.

All research materials will be provided in English and a host of local languages (such as Xhosa and Zulu). Interviewers will explain all aspects of the project to children and answer any questions they may have in child's preferred language.

It is important to recognise that the inequalities between researcher and participant can also function as a positive attribute. For example, children reported in feedback for the Young Carers qualitative (and previous) studies, that they appreciated the opportunity to speak to a sympathetic, motherly adult about their lives. They often took the opportunity to ask our interviewers about issues raised by the questionnaire, such as how to get a school-fees exemption. With this example, all children who could not afford school fees were also sent information and support letters to take to their schools in applying for exemption.

- (d) Describe any *financial or other rewards which will be offered to participants.

All children will be given small snacks such as fruit to eat while being interviewed. Following participation all participants will receive a Certificate of Participation (attached) regardless of completion.

As in previous research which we have conducted, we will not use financial rewards as they have a tendency to lead to problems involving jealousy within the community or household. Carrying around money also places interviewers and children at risk in high-crime areas of South Africa.

We have consistently found an overwhelming level of agreement to participate in these studies, based on an understanding of the policy-focused nature of the project, and its close collaboration with government and NGOs.

11. *Participant information

It is essential that written information is easily understandable by participants. Failure to provide this information in appropriate lay language is the most frequent reason for delays in ethical approval.

(a) Will participants receive written information about the project before giving their consent?

☒ Yes - please attach.

☐ No - give reasons.

Child questionnaire (with information and consent form on first pages)

Guardian consent form for child participation

Adult caregiver questionnaire

Adult caregiver information and consent form

(b) Who will give the participants the information and how?

All information sheets and consent forms will be given to children and their caregivers or nominated adult by the interviewer. All information sheets and consent forms will be read to participants in their preferred language to prevent illiteracy from hindering a participant's understanding about the methods and purpose of the study. All participants will be told they have the right to decline to participate, drop out at any time, and that all the results will remain confidential.

Once consent has been obtained from both the child and caregiver or nominated adult, the questionnaire booklet will be read to the child, and positioned so that both interviewer and participant can see the pack. Interview materials have been designed in conjunction with a Teen Advisory Group specifically to cater to our target group's tastes.

A full and independent pilot of the child questionnaire will be undertaken by an Honours Psychology student at the University of Cape Town, supervised by Dr Lauren Wild (July-Aug 2009). This will further allow scrutiny and participant input into improving the design and content of the questionnaire.

Following the interview, participants will once again be encouraged to ask any questions they may have regarding the research, and will be given an opportunity to have their book destroyed rather than included in the study.

(c) Does the research involve deliberate *deception of participants?

☐ Yes- explain why the real purpose of the research needs to be concealed and how and when participants will be told of the deception.

☒ No

(d) Please describe the basis on which you have decided how long participants will have to think about the information provided before giving consent.

Participants may consent to participate only after having the information sheet been read to them and there has been an opportunity for questions. This way they are fully informed about the study and have had the chance to ask any questions that might have arisen.

Participants will have the opportunity to consider consent for up to a week, before interviewers return. However, when we have previously offered participants periods of 24 hours to 1 week to consider consent, the vast majority have requested to participate immediately. In light of this, we propose that participants are offered the choice of whether

to consent or refuse immediately, or to have 1-7 days to consider whether they choose to consent.

12. *Informed consent

(a) Will you obtain written consent?

☒ Yes - please attach *consent form.

☐ No - explain how consent will be obtained and recorded and why this method is used.

(b) If participants are unable to give valid consent, how and from whom will you obtain consent? [Please see the [Glossary](#) on the CUREC website for information on how the meaning of *capacity to consent has been altered by the Mental Capacity Act 2005]

All participants should be capable of giving their own consent, and we will not interview any children or adults deemed incompetent. Special care will be taken to ensure that all participants are fully aware of and understand the research, and in these particular cases, all consent procedures will be supervised by a social worker or facilitator experienced in working with vulnerable children.

(c) List those researchers who will, with the authorisation of the principal researcher (or supervisor in the case of student researchers), secure the consent of participants.

Marisa Casale (PhD candidate)

Caroline Kuo (DPhil candidate)

Tyler Lane (DPhil candidate)

Kerry Mauchline (DPhil candidate)

Research assistants yet to be hired (although in three provinces these will be Research Assistants who have worked for us on previous studies). All RAs will be thoroughly trained on gaining informed consent, and a random sub-set of interviews will be digitally recorded and reviewed independently, including review of informed consent procedures.

13. Consequences of participation

(a) What are the potential risks or actual ill effects of participation (if any) e.g. invasive procedures, distress, deception etc, and what will be done to minimise these risks

(i) to the participants?

The focus of this study is the impact of being a Young Carer for an unwell family member in South Africa. We do not anticipate that the interviews will cause any distress either to children or their caregivers. However, in order to reduce any risk of caregivers or children becoming distressed:

Interview materials are designed to look like teen magazine quizzes, so that participants have more fun while completing them.

As in all research with children, there is a small possibility that participants will take the opportunity to disclose difficult living circumstances or abuse. This study recognises that researchers have a responsibility towards children who may disclose information showing them to be at risk of severe harm.

In order to protect confidentiality of the participants from the stigma associated with HIV/AIDS, each interview will be conducted with as much privacy as possible. Though this is difficult in crowded areas, during our qualitative study we were able to come up with creative ways to obtain privacy (such as conducting interviews outside, or in local libraries).

Recent research in South Africa has carefully considered these issues. Guidelines are set out by the ongoing HSRC/UNICEF study on children's psychological adjustment in South Africa (Dawes, Bray, Kvalsvig, & Richter, 2007) and in the South African Children's Institute/ACCESS Child Participatory Poverty Research (ACCESS, 2002). These promise confidentiality except when a child is shown through the research to be at risk, in which case (with the child's consent) they will be referred to organisations that can provide assistance (ACCESS study), or caregivers will be told (UNICEF study).

It is to be noted that the majority of research with vulnerable children in South Africa considers it an ethical principle to provide help for children whom the research identifies as in need. For example, research undertaken by the Medical Research Council Unit for Anxiety and Stress Disorders routinely refers children to child psychiatric services or to the University of the Western Cape Child Psychology clinic where there is need for these services (Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004; Seedat, van Nood, Vythilingum, Stein, & Kaminer, 2000). A University of Cape Town study on child mental health referred children in need to social services, as does ongoing research in the Africa Centre on HIV+ caregivers and infants (Stein et al., 2005). Following these, and protocols devised from research studies with similarly vulnerable groups (Bostock, 2002) the following protocol is proposed. This protocol has been used in our previous three studies with AIDS-affected children in South Africa, and has been approved by Oxford, University of Witwatersrand, and University of Cape Town Research Ethics Committees.

Informing all participants at the consent stage that everything said will be confidential unless it becomes clear that they are at risk of significant harm.

If information is disclosed that suggests that any member of the household is at risk of significant harm, the researcher will discuss concerns with the child at the end of the interview.

If the members of the household consent, the caregiver will be informed (unless this is thought to put the child at risk) and the researcher will discuss the possibilities for referral to child welfare, health organisations, etc. If the child does not consent to sharing of information, and the harm is not considered to be significant, the child will be given information about self-referral agencies such as ChildLine SA. However, if the harm is considered to be significant the researcher will consult with social services or other organisations. If the decision is made to take action, the participant(s) will be informed (*Please see attached draft referral form*).

(ii) to the researchers?

No risks to the research staff as a result of this project are foreseen. There are the general risks of working in urban poor areas, and we ensure that all RAs and fieldwork staff are trained in awareness and safety measures. We provide all staff with panic alarms. Staff do not undertake interviews in any situation in which they feel uncomfortable or unsafe, and are encouraged to travel in pairs in areas which are less safe.

All staff cars are equipped with tools, spare tyres, water and oil, and all staff who are driving staff cars are trained in basic car maintenance.

(iii) to others (e.g. the university, family)?

No risks to others are foreseen.

(b) Is there a need for support or counselling?

☒ Yes - describe the form of support or counselling and how, when, and by whom it will be conducted.

☐ No

This study has an obligation to plan for the possibility of participants, child or adult, becoming distressed. All interviews will be trained and experienced in working with affected children and families. The research team will include a qualified social worker who will be available to discuss any issues with the families and children following the interviews. As discussed above, if there is a need for a participant to access more extensive support (such as seeing a counsellor or attending a clinic) referrals will be made (*Please see attached draft referral form*).

Is there a need for debriefing or follow-up discussion?

☒ Yes - describe the form of debriefing or follow-up discussion and how, when, and by whom it will be conducted.

☐ No

We are obligated to any participant who may feel distressed following the study. All interviewers are trained and experienced in working with affected children and their families. If a participant is to become distressed, interviewers will be available to discuss any issues he or she may have, and make referrals if required. Interviewers also contact the project manager by cellphone when they have a particular concern, or when a participant requires information or discussion.

Are there any potential benefits to the participants?

☒ Yes - describe them below

☐ No

Previous participatory studies with children in South Africa have been reported by child participants to be beneficial and stimulating (ACCESS, 2002; Clacherty & Budlender, 2003). Children in the qualitative study reported enjoying participating in the study, enjoyed the snacks and certificates they received, and many said they appreciated being asked questions about their lives, and appreciated the warmth and interest of the interviewer.

Indirect benefits include the research goals of informing government policy for their benefit, programming, and legislation for Young Carers in South Africa.

14. *Adverse events

How will adverse events be monitored and reported?

Please see above for protocols connected to any disclosure by children during research process. Interviewers will address any minor accidents or injuries which may happen as the research is taking place. Any adverse events will result in immediate contact with supervisors and in depth conversations to discuss appropriate actions.

15. Monitoring

Explain how and by whom (e.g. supervisor in the case of student research projects) the ethical aspects of the project will be monitored to ensure that they conform to the procedures set out in this application.

The student researchers will have weekly teleconference meetings with the supervisor, and several in person meetings while the supervisor is in the field.

All student researchers and RAs will be trained in responding to child disclosure and in communicating with children, by an independent Social Work lecturer (Dr Charlotte Ritchie).

The PI (Dr Lucie Cluver) is a qualified social worker, and will monitor ethical processes on regular field visits.

SECTION 4: RESEARCH INVOLVING COLLECTION, USE, OR *DISCLOSURE OF *PERSONAL DATA

Your project must meet the standards laid down in the Data Protection Act (1998) with respect to the collection, use, and storage of *personal data about *human participants.

Please delete questions or parts of questions that you are not required to answer to save paper.

16. Need I complete this section?

Does the project involve the collection, use or disclosure of personal information including sensitive and/or genetic information?

☐ No – you need not complete this section. Go to Section 5.

☒ Yes – you must answer questions in this section. Go to Question 17.

17. Type of activity proposed

Does the research involve:

(a) disclosure of personal information?

☒ Yes

☐ No

(b) collection of personal information?

☒ Yes – go to Question 18

☐ No – go to Question 20

18. Collection of information directly from individuals

(a) Does the project involve collection of information directly from individuals about themselves?

☐ No – go to Question 19.

☒ Yes – answer the following questions:

(b) Do the *participant information and the *consent form include the following:

the name of the study?	☒ Yes ☐ No
the name and status (e.g. doctoral student) of the researcher collecting the information and how to contact him/her?	☒ Yes ☐ No
the purpose of the study?	☒ Yes ☐ No
declarations that the participant has read the participant information sheet?	☒ Yes ☐ No
has had the opportunity to ask questions about the study and has received satisfactory answers to questions, and any additional details requested?	☒ Yes ☐ No
understands that s/he may withdraw from the study without penalty at any time by advising the researchers of this decision?	☒ Yes ☐ No
understands that this project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee?	☒ Yes ☐ No

understands who will have access to personal data provided, how the data will be stored; and what will happen to the data at the end of the project?	☒ Yes ☐ No
agrees to participate in this study?	☒ Yes ☐ No
understands how to raise a concern and make a complaint?	☒ Yes ☐ No

If you answered 'no' to any of these questions, explain why this information has not been included in the participant information and the consent form.

(c) Are the consent form and participant information on headed letter paper which bears the name of the University and the name and address of the department to which the principal researcher is attached?

☒ Yes

☐ No - explain why not.

(d) Are the participant and the researcher who secures the consent required to sign, print and date their names?

☒ Yes

☐ No -explain why not.

19. Collection of information from a third party

(a) Does the project involve collection of information about an individual from a source other than the individual?

☒ No – Go to Question 20.

☐ Yes – complete the following sections.

20. Form in which data are to be stored

Are the data to be kept

(a) with an open identifier i.e. in non-anonymised form ☐ Yes ☒ No

(b) as anonymised but potentially identifiable data ☒ Yes ☐ No

(c) as anonymised, non identifiable data ☐ Yes ☒ No

21. Use or disclosure of information about individuals

(a) Does the project involve the use or disclosure of information potentially or actually ascribed to an individual?

☐ No – go to Question 22.

☒ Yes – answer the following questions

(b) Does the project involve use or disclosure of information without the consent of the individual whom the information describes?

☒ No – go to Question 22.

☐ Yes – answer the following questions:

22. Data collection, storage, and disposal

- (a) How many records will be collected, used or disclosed? Specify the information that will be collected, used, or disclosed e.g. date of birth, medical history, number of convictions.

Number of records: The number of children (6000) and the number of caregivers (~1500)

Type of information: Quantitative. We will be collecting child and caregiver date of birth, education history, what kind of care/domestic work the children are engaged in, responses to standardised questionnaires regarding physical, psychological, social and educational outcomes, and ill person illness and symptoms. We will not place emphasis on HIV/AIDS illness but are prepared for private disclosure. We are mainly relying on symptoms and the Verbal Autopsy (VA) for confirmation of AIDS illness.

- (b) How, where, and under what security arrangements will electronic and paper data be stored? Who will have and control access to the information?

Electronic data will be stored on a password-protected computer, and paper data will be stored in locked cabinets. Availability of this data will be limited to lead researchers on this team.

- (c) When, how and by whom will the information be disposed of?

Information will be disposed of by lead researchers following completion of this study.

- (d) How will the privacy of individuals be respected in any publication arising from this project?

In reporting the findings of this study, we will omit names and only report locations in which the study took place. Data will be kept for a period of up to five years after collection in an anonymised version.

(e) Have you explained in the *participant information and *consent form that maintenance of confidentiality of information is subject to normal legal requirements?

☒ Yes

☐ No – explain why not.

23. Adverse and unforeseen events

How will adverse and unforeseen events relating to the collection, use, or disclosure of information be managed, monitored and reported?

Any adverse events will be reported to the principal investigator. All precautions will be taken to ensure confidentiality for all participants. We do not anticipate adverse events of this kind due to the confidentiality of the participants' information.

SECTION 5: MISCELLANEOUS ISSUES

24. *Conflict of interest

(a) Do researchers on this project have a financial or other interest in its conduct or outcomes?

☐ Yes – give details.

☒ No

(b) If there is a conflict of interest, have you declared it in your *participant information and *consent form?

☐ Yes

☐ No – explain why not.

N/A

(c) Are there any other potential conflicts of interest e.g. research findings that could compromise the researcher's relationship with the university?

None

25. *Peer review

Has this project been peer reviewed?

☒ Yes – explain by whom (e.g. by a, tutor, supervisor, funding body etc) and with what outcome

☐ No – explain why not.

This project has been reviewed by all of the primary investigators, the South African Department of Social Development, the South African Department of Health, the South African Department of Education, the National Action Committee of Children Affected by AIDS, Save the Children and UNICEF.

26. Funding

List all bodies and individuals from whom funding has been or will be sought.

Source	Amount in £	Status of Funds	
		Available	Applied for
HEARD	£400,000	Yes ☒ No ☐	Yes ☐ No ☐
John Fell Fund	£67, 000	Yes ☒ No ☐	Yes ☐ No ☐
Economic and Social Research Council	£500,000	Yes ☐ No ☐	Yes ☒ No ☐
Leverhulme Foundation	£450,000	Yes ☐ No ☐	Yes ☒ No ☐

27. Reporting of results

(a) Will the project outcomes be made public at the end of the project?

☒ Yes – describe the intended report and how and to whom it will be made available.

☐ No – explain why not

The research will be of interest to government officials from various departments, including the Department of Social Development, Health, Education, and Agriculture. The feedback of findings to government will take place at a national level (to NACCA steering committee meetings) in addition to provincial level and district level local government.

Additionally, the study findings will be reported at key conferences (such as the South African AIDS Conference), and will be provided as a set of lay-term, 1-page ‘policy briefs’ which will be sent to NGOs and will be downloadable freely on our website. Results will also be reported on the study website www.youngcarers.net.au

We will make all efforts to provide participant children and adults with ‘brief reports,’ regarding the progress of the research. This will focus on positives, and make no mention of HIV/AIDS.

(b) Will a report(s) of the project outcomes (for example, individual or group data) be made available to participants at the end of the project?

☒ Yes – describe report and how it will be made available.

☐ No – explain why not.

☐ N/A

Feedback to participants is a key part of a child-focus research design (Herth, 1998). At each stage of review and data collection, the study will create ‘brief reports’: easily understandable summaries of study findings in lay language. These will focus on findings relevant to NGOs and schools in their work with children. In ongoing pilot work, local NGO staff and teachers have requested training sessions rather than paper reports, and the research team will aim to deliver this where possible.

All participating children and families will also receive ‘brief reports’ as described in section 27a.

28. Declaration by researchers

Full project title:

I/We, the researcher(s) agree:

- To start this research project only after obtaining approval from IDREC/CUREC;
- To carry out this research project only if funding is adequate to enable it to be carried out according to good research practice and in an ethical manner;
- To provide additional information as requested by IDREC/CUREC before approval is secured and as research progresses;
- To maintain the confidentiality of all data collected from or about project participants;
- To notify IDREC in writing immediately of any proposed change which would increase the risks that any participant is exposed to and await approval before proceeding with the proposed change;
- To notify IDREC if the principal researcher on the project changes and supply the name of the successor;
- To notify IDREC in writing within seven days if any serious *adverse event occurs in the course of research;
- To use data collected only for the study for which approval has been given;
- To grant access to data only to authorised persons; and
- To maintain security procedures for the protection of personal data, including (but not restricted to): removal of identifying information from data collection forms and computer files, storage of linkage codes in a locked cabinet and password control for access to identified data on computer files.

FAQs

FAQ

Signed by principal researcher:.....

Date:.....

Print name (block capitals).....

Signed by associate/other researcher:

Print name (block capitals).....

Date

29. Certification by *principal researcher/supervisor/student researcher and head of department

Full project title:

Certification by *principal researcher

I accept responsibility for the conduct of this research project.

I certify that all researchers and other personnel involved in this project are appropriately qualified and experienced or will undergo appropriate training to fulfil their role in this project.

Signed by principal researcher/supervisor/student researcher:.....

Date:.....

Print name (block capitals).....

Acceptance by head of department/other senior member of the department if the principal researcher is the head of department

I have read the research project application named above.

On the basis of the information available to me, I judge the principal researcher/supervisor/student researcher to be award of her/his ethical responsibilities in regard to this research. I am satisfied that the proposed project has been/will be subject to appropriate peer review and is likely to contribute to existing knowledge and/or to the education and training of the researcher(s) and that it is in the public interest.

Name of head of department/other senior member of the department (e.g Chair of DREC, Director of Graduate Studies for student projects):

.....

Signature

Date.....

FINAL CHECK

To prevent delay please check each of the following before submitting the application.

Have you answered all relevant questions in Sections 1-5? ☐

Have you defined all technical terms and abbreviations used? ☐

Have you included all questionnaires and participant information, consent forms, advertisements, and surveys to be used? ☐

Have you included all relevant approvals and supporting letters? ☐

Have you declared all potential conflicts of interest? ☐

Are all pages (including appendices and attachments) numbered? ☐

Have you completed the declaration by researcher(s)? ☐

Have you completed the certification by principal researcher and head
of department?

☐

Revised July 2008

Appendix 2 Ethics committee approval letters

Interdepartmental Ethics Committee (IDREC) Oxford

SOCIAL SCIENCES & HUMANITIES
INTER-DIVISIONAL RESEARCH ETHICS COMMITTEE

Hayes House, 75 George Street, Oxford. OX1 2BQ
Tel: +44(0)1865 614871 Fax: +44(0)1865 614855
ethics@socsci.ox.ac.uk www.socsci.ox.ac.uk

Co-ordinator of the IDREC
Social Sciences Divisional Office



Ref. SSD/2/3/IDREC

08.12.09

Dr. Lucie Cluver
Department of Social Policy and Social Work,
Barnett House
32 Wellington Square
Oxford
OX1 2ER

Dear Dr. Lucie Cluver,

Application for research ethics approval

Ref No.: SSD/CUREC2/09 – 52

Title: Young Carers for AIDS-ill family members in South Africa: Predictors for providing care and psychological, health, and educational outcomes

The above application has been considered on behalf of the Social Sciences and Humanities Inter-divisional Research Ethics Committee (IDREC) in accordance with the procedures laid down by the University for ethical approval of all research involving human participants.

I am pleased to inform you that, on the basis of the information provided to the IDREC, the proposed research has been judged as meeting appropriate ethical standards, and accordingly approval has been granted.

Should there be any subsequent changes to the project, which raise ethical issues not covered in the original application, you should submit details to the IDREC for consideration.

A handwritten signature in black ink that reads 'Chris Ballinger'.

Dr Chris. Ballinger

cc: Elaine Evers, Department of Social Policy and Social Work

HBP/CAJB

Department of Social Development



social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

PRIVATE BAG X901
PRETORIA
0001

Enquiries: Dr M.C. Kganakga
Tel: (+27) 12 312 7962 / 7963
Fax: 086 615 5478
E-mail: malegak@socdev.gov.za

Attention: Dr Lucie Cluver and Dr Don Operario
Oxford University and Brown University

To Whom It May Concern:

The Department of Social Development wishes to offer support for your research to study health and psychological risk outcomes for South African children affected by HIV and AIDS. There is a need for rigorous research to guide prevention, intervention and policy initiatives for children affected by HIV and AIDS. This proposed work will provide a foundation for evidence-based responses.

We are pleased that this research focuses on children with unwell parents in addition to orphaned children, as this will help to clarify the processes by which children experience health and psychological adversity. This information can also point to strategies for ameliorating the stress experienced by children affected by HIV and AIDS.

The Department will be pleased to offer technical support during the various phases of the research effort. This will be accomplished through regular meetings and consultations with the National Action Committee for Children Affected by HIV and AIDS (NACCA). The Department wishes to acknowledge the institutions' involvement in the current and previous research efforts on orphans and other children made vulnerable by HIV and AIDS.

The Department wishes you every success in this research.

Kind Regards,


DIRECTOR GENERAL
DATE 15/12/08

Department of Health, KwaZulu-Natal



Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM091/09
Enquiries : Mrs G Khumalo
Telephone : 033 – 3953189

05 August 2009

Dear Dr Cluver

Subject: Approval of a Research Proposal

1. The research proposal titled **'Young Cares for AIDS-ill family members in South Africa: Predictors for providing care and psychological, health and educational outcomes'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at **KwaZulu-Natal amongst the Durban community.**

2. You are requested to undertake the following:
- Make the necessary arrangement with the identified community before commencing with your research project.
 - Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-3953189.

Yours Sincerely

Dr S.S.S. Buthelezi
Chairperson, Health Research Committee
KwaZulu-Natal Department of Health

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Department of Health Mpumalanga

26/02 2010 10:15 FAX 0137863458

HEALTH

002

MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3
No. 7 Government Boulevard
Riverside Park Extension 2
Nelspruit
1200
Republic of South Africa



Private Bag X 11213
Nelspruit, 1200
Tel: 013 766 3429
int: +27 13 766 3429
Fax: 013 766 3491
int: +27 13 766 3491

Department of Health

Litoko Letemphilo

Umyango WezaMaphilo

Departement van Gesondheid

Enquiries: Kate Mathe 3102

25 February 2010

Dr Mosa Moshabela
University of Witwatersrand
Rural AIDS and Development Action Research (RADAR)
P O Box 02
Acornhoek
1360

Dear Dr Mosa Moshabela

APPLICATION FOR RESEARCH & ETHICS APPROVAL: YOUNG CARERS FOR AID-
UNWELL PARENT; MENTAL HEALTH, PHYSICAL HEALTH, SOCIAL AND EDUCATIONAL
OUTCOMES: "KIDS WHO CARE".

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent. No issues of ethical consideration were identified.

Kindly ensure that you provide us with the report once your research has been completed.

Kind regards,

Molefe Machaba
Research and Epidemiology

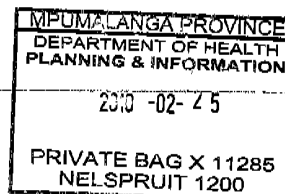
Mpumalanga PHREC
Chairperson: Dr Mosa Moshabela

25-02-2010
Date

25/02/2010
Date



Siyavakhelela



Department of Education KwaZulu-Natal

17. Aug. 2009 16:39

No. 5506 P. 1



PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI

DEPARTMENT OF EDUCATION
UMNYANGO WEMFUNDO

Tel: 033 341 8610
Fax: 033 341 8612
Private Bag X9137
Pietermaritzburg
3200

228 Pietermaritz Street
PIETERMARITZBURG

INHLOKHOVISI		PIETERMARITZBURG	HEAD OFFICE
Imibuzo:	Reference:	Date:	
Enquiries: Sibusiso Alwar	Inkomba: 0048/2009	Usuku: 30 July 2009	

MR T LANE
DEPARTMENT OF SOCIAL POLICY
AND SOCIAL WORK BARNETT HOUSE
32 WELLING SQUARE
OXFORD OX1 2ER
UK

RESEARCH PROPOSAL: YOUNG CARERS OF AIDS-UNWELL CAREGIVERS IN SOUTH AFRICA RESEARCH PROPOSAL.

Your application to conduct the above-mentioned research in schools in the attached list has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educator programmes are not to be interrupted.
5. The investigation is to be conducted from 30 July 2009 to 30 July 2010.
6. Should you wish to extend the period of your survey at the school(s) please contact Mr Sibusiso Alwar at the contact numbers above.
7. A photocopy of this letter is submitted to the principal of the school where the intended research is to be conducted.
8. Your research will be limited to the schools submitted.
9. A brief summary of the content, findings and recommendations is provided to the Director: Resource Planning.

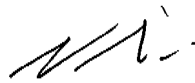
RESOURCES PLANNING DIRECTORATE: RESEARCH UNIT
Office No. G25, 188 Pietermaritz Street, PIETERMARITZBURG, 3201

10. The Department receives a copy of the completed report/dissertation/thesis addressed to

The Director: Resource Planning
Private Bag X9137
Pietermaritzburg
3200

We wish you success in your research.

Kind regards



R. Cassius Lubisi (PhD)
Superintendent-General

RESOURCES PLANNING DIRECTORATE: RESEARCH UNIT
Office No. G25, 188 Pietermaritz Street, PIETERMARITZBURG, 3201

Department of Education Mpumalanga



education
DEPARTMENT: EDUCATION
MPUMALANGA PROVINCE

Private Bag X 11341
Nelspruit 1200
Government Boulevard
Riverside Park
Building 5
Mpumalanga Province
Republic of South Africa

Litiko letemfundvo uninyango weFundo Departement van Onderwys uninyango wezemfundo
Enquiries: A.H Baloyi (013) 766 5476

11 May 2010

Dr. L. Cluver
Department of Social Policy and Social Work
Barnett House
32 Wellington Square
OXFORD

RE: APPLICATION TO CONDUCT RESEARCH IN THE DEPARTMENT.

Your application (dated 10 May 2010) to conduct research on the topic: "Young carers for AIDS-unwell parents: mental health, physical health, social and educational outcomes" was received on the 11 May 2010.

Your abbreviated proposal, especially the purpose and the background gives an impression that your study will benefit the entire department especially the affected learners. Given the motivation and the anticipated report of the study, I approve your application to conduct your research in the institutions of the department as per your approved research proposal.

You are further requested to read and observe the guidelines as spelt out in the attached research manual.

The importance of this study cannot be overemphasized; therefore you are expected to share your findings with the department. It will be appreciated if you can present your findings in electronic form and make formal presentation to the research unit.

For more information kindly liaise with the department's research unit @ 013 766 5476 or a.baloyi@education.mpu.gov.za.

The department wishes you well in this important study and pledge to give you the necessary support you may need.

MRS MOC MHLABANE
HEAD OF DEPARTMENT
DATE: 15/05/2010

Together Educating the Nation



Department of Education Western Cape

Navrae
Enquiries
IMibuzo
Telefoon
Telephone
IFoni
Faks
Fax
IFeksi

Dr A.T Wyngaard

021 467 9272

(021) 425-7445

Verwysing
Reference
ISalathiso

20100225-0034



Wes-Kaap Onderwysdepartement

Western Cape Education Department

ISebe leMfundo leNtshona Koloni

Dr Lucie Cluver
Barnett House
32 Wellington Square
Oxford
OX1 2ER
United Kingdom

Dear Dr Lucie Cluver

RESEARCH PROPOSAL: YOUNG CARERS FOR AIDS-ILL FAMILY MEMBERS IN SOUTH AFRICA: PREDICTORS FOR PROVIDING CARE AND PSYCHOLOGICAL, HEALTH AND EDUCATIONAL OUTCOMES

Your application to conduct the above-mentioned research in schools in the Western Cape has been approved subject to the following conditions:

1. Principals, educators and learners are under no obligation to assist you in your investigation.
2. Principals, educators, learners and schools should not be identifiable in any way from the results of the investigation.
3. You make all the arrangements concerning your investigation.
4. Educators' programmes are not to be interrupted.
5. The Study is to be conducted from **10 February 2010 to 30 September 2010**.
6. No research can be conducted during the fourth term as schools are preparing and finalizing syllabi for examinations (October to December).
7. Should you wish to extend the period of your survey, please contact Dr A.T Wyngaard at the contact numbers above quoting the reference number.
8. A photocopy of this letter is submitted to the principal where the intended research is to be conducted.
9. Your research will be limited to the list of schools as forwarded to the Western Cape Education Department.
10. A brief summary of the content, findings and recommendations is provided to the Director: Research Services.
11. The Department receives a copy of the completed report/dissertation/thesis addressed to:

**The Director: Research Services
Western Cape Education Department
Private Bag X9114
CAPE TOWN
8000**

We wish you success in your research.

Kind regards.

Signed: Audrey T Wyngaard

for: **HEAD: EDUCATION**

DATE: 25 February 2010

MELD ASSEBLIEF VERWYSINGSNOMMERS IN ALLE KORRESPONDENSIE / PLEASE QUOTE REFERENCE NUMBERS IN ALL CORRESPONDENCE /
NCEDA UBHALE IINOMBOLO ZESALATHISO KUYO YONKE IMBALELWANO

GRAND CENTRAL TOWERS, LAER-PARLEMENTSTRAAT, PRIVAATSAK X9114, KAAPSTAD 8000
GRAND CENTRAL TOWERS, LOWER PARLIAMENT STREET, PRIVATE BAG X9114, CAPE TOWN 8000

WEB: <http://wced.wcape.gov.za>

INBELSENTRUM /CALL CENTRE

INDIENSNEMING- EN SALARISNAVRAE/EMPLOYMENT AND SALARY QUERIES ☎ 0861 92 33 22

VEHICE SKOLE/SAF SCHOOLS ☎ 0800 45 46 47

University of KwaZulu-Natal



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

14 JULY 2009

DR. L. CLUVER
HEARD

Dear Dr. Cluver

ETHICAL CLEARANCE: "THE CARER-CHILD WELLBEING PROJECT: KWAZULU NATAL UKUNAKEKELA PROJECT"

I wish to confirm that ethical clearance has been granted for the above project, subject to independent contact information being included on the information sheet:

This approval is granted provisionally and the final clearance for this project will be given once the above condition has been met. Your Ethical Clearance Number is HSS/0254/09

Kindly forward your response to the undersigned as soon as possible

Yours faithfully


.....
MS. PHUMELELE XIMBA
ADMINISTRATOR
HUMANITIES & SOCIAL SCIENCES ETHICS COMMITTEE

cc. Prof. D Operario
cc. Ms. C Kuo
cc. Casale Marisa

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

University of Cape Town



UNIVERSITY OF CAPE TOWN

**Health Sciences Faculty
Research Ethics Committee**
Room E52-24 Groote Schuur Hospital Old Main Building
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
e-mail: lamees.emjedi@uct.ac.za

22 September 2009

REC REF: 389/2009

Dr LD Cluver
Social Policy & Social Work
University of Oxford

Dear Dr Cluver

**PROJECT TITLE: YOUNG CARERS FOR AIDS-ILL FAMILY MEMBERS IN SOUTH AFRICA:
PREDICTORS FOR PROVIDING CARE AND PSYCHOLOGICAL, HEALTH, AND
EDUCATIONAL OUTCOMES**

Thank you for submitting your study to the Research Ethics Committee for review.

It is a pleasure to inform you that the Ethics Committee has **formally approved** the above-mentioned study.

Approval is granted for one year until 30 September 2010.

Please submit an annual progress report if the study continues beyond the approval period. Alternatively please submit a brief summary of your findings so that we can close our records.

Section 3 Point 9 (c) (2). In paragraph 5 please note that the Children's Act of 2005 does not include any reference to children and research.
The National Health Act provides for children's participation in therapeutic and non-therapeutic research. However, the relevant section (section 71) is not yet enacted

Please note that the ongoing ethical conduct of the study remains the responsibility of the **principal** investigator.

Please quote the REC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, HSE HUMAN ETHICS

pp

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines I:6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulations Part 50, 56 and 312.

Appendix 3 Consent forms

Caregiver consent form

Caregiver consent form

Dear Parents/Guardians

We would like to invite your child to take part in research that is being run by a number of universities and by the South African government. The research will be asking about the well-being of children in South Africa. We will be talking to 6000 children in four different provinces and the research will take what children and their carers say to the South African Government and to other organisations working with children. The government will use this research to help their planning for children.

This research will be asking young people about their everyday lives, their feelings and their relationships. If you give permission, your child will fill in a questionnaire, with the help of an interviewer. This will take about an hour. Young people can choose whether they want to take part or not, and they can stop the interview at any time. Everything we are told will be treated as entirely confidential, unless children are at risk of serious harm, in which case we will try to help.

If you have any questions or worries about the research, please tell a member of our research team and they will be very happy to discuss or explain further to you.

Please fill in the slip below and let us know whether you give permission.

Thank you,

Lucie Cluver

Dr Lucie Cluver (Researcher), Cape Town Child Welfare



If you have any questions or complaints about this study, please contact Dr Lucie Cluver at Cape Town Child Welfare: 021 638 3127
Email: lucie.cluver@socres.ox.ac.uk

Privacy code:

Name of Participant	Child's grade
Can the child I care for take part in this study?	YES NO
Name of parent/guardian.....	Date



Child consent form

TEEN TALK 2 SOUTH AFRICA

Just like last time, please take time to read this sheet carefully and decide whether you do or don't want to take part. Ask the research team if there is anything that is not clear or if you have questions. Thank you for reading this.

What is this study about? This study is about young people and their feelings about their lives. The government wants to know more so they can plan how to help young people and families better.

Do I have to take part? Not at all. It is up to you to decide whether or not to take part. If you do not want to, this will not affect any help you may be getting from anyone. You will not get in any trouble if you do not want to take part.

If you decide to take part, you are still free to stop at any time. You don't have to give a reason. Again, this will not affect any help or support you are getting from anyone. We may come back in the future to see how you are doing. You can choose then whether you want to talk to us again!

What would I have to do? If you decide to take part, you will first sign a consent form (on the next page), and then spend about an hour talking together and doing activities with a researcher.

What if the questions upset me? You can stop at any point, and you do not have to give a reason. You can also contact the research team at any point after the group, and say that you want your answers about certain questions to be destroyed, which we will do straight away. If you want to talk to someone about anything that has come up from this, you can tell one of the researchers or contact the Young Carers Team at Cape Town Child Welfare (021 638 3127).

Why should I take part in this study? This may help us to know more about what can help young people in South Africa. What you tell us will help inform future government policy.

What if I have a complaint? If there is anything to do with this research which you are unhappy with, you can complain to Dr. Lucie Cluver at Oxford University (lucie.cluver@socres.ox.ac.uk).

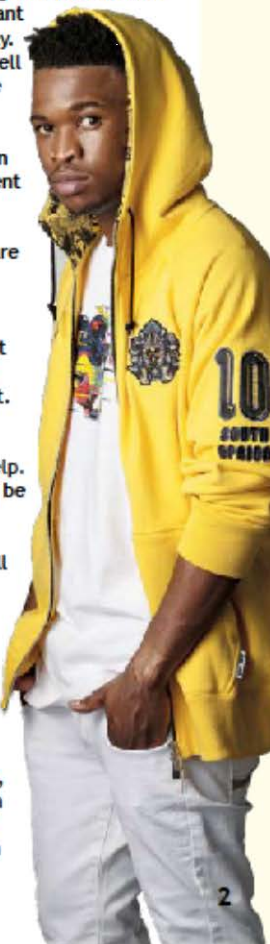
Will what I say be kept confidential? Anything you tell us about yourself will be kept strictly confidential, and will not be told to anyone else. Any information about you would have your name and address changed so that you cannot be recognised from it.

But during this study, it may become clear that you are suffering from serious difficulties. If so, the interviewer will explain to you some possibilities for further help. If there is a safety issue, we may contact a welfare organisation for you. All this will be talked over with you first.

What will happen to the results of the research study? The results of this study will be used to help the government and others to make policies for young people and families in situations much like yours.

Who is organising and reviewing the research? The research is being organised by the University of Oxford in England, the University of Witwatersrand, the University of KwaZulu-Natal and the University of Cape Town. The research is also working with the Department of Social Development, the Department of Health and the Department of Basic Education in Pretoria. Ethics groups in both countries have approved the research. If you have any complaints about ethics in the Western Cape, please contact the UCT Health Sciences Research Ethics Committee (E52-23 Old Main Building, Groote Schuur Hospital, Observatory, 7925). If you have any complaints in Mpumalanga or in Gauteng, please contact the University of Witwatersrand Research Ethics Committee - telephone: (011) 717 7123/4.

INFORMATION



Contact for further information: Dr Lucie Cluver, Cape Town Child Welfare, Lower Klipfontein Road, Gatesville, Athlone, South Africa 8000. Email: lucie.cluver@socres.ox.ac.uk

Thank you for reading this sheet. If you feel comfortable with everything, you can fill in the box:

Do I want to take part?

Tick:

1. I have read and understand the information sheet for this study and have had the chance to ask questions
2. I understand that I have chosen to take part and that I am free to stop at any time, without giving any reason. This will not change any support or help I am getting
3. I agree that any words I may say during the interview can be used, without giving my name, in the presentation of the research. I agree to take part in the study

☐
☐
☐

Sign:

.....
Name of participant

.....
Signature

.....
Name of researcher

.....
Date



Could you give us the names, addresses and telephone numbers of 2 people (who you don't live with) who you think would know how to contact you in a few years time?

1.
.....
.....
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.....
.....
.....
.....
2.
.....
.....
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.....

Appendix 4 Certificates

Baseline certificate



Follow-up certificate front



Back of certificate

Important details for you to keep

If you want to talk about anything that has come up from the study, or have a complaint about the study, you can contact:

The Young Carers Team at Cape Town Child Welfare
Lower Klipfontein Road, Gatesville,
Athlone, South Africa 8000
Email: lucie.cluver@socres.ox.ac.uk
TELEPHONE: (021) 638 3127

If you have a complaint about the ethics of the study, you can contact:

UCT Health Sciences Research Ethics Committee
E52-23 Old Main Building, Groote Schuur Hospital, Observatory, 7925

If you are being hurt or frightened by other people or adults, and need help, you can contact:

Childline
TELEPHONE: 0800 055 555 (toll free)

Cape Town Child Welfare
TELEPHONE: 0800 43 57 54 (toll free)

Police Station (local)
TELEPHONE: 10111

If you would like some advice or information about HIV/AIDS, you can contact:

Lovelife (for advice on sexual matters)
TELEPHONE: 0800 121 900 (toll free)

National AIDS Helpline
TELEPHONE: 0800 012 322 (toll free)



Appendix 5 Examples of referral letters

Referral checklist

Referral's Checklist

Needs/Experiences/Symptoms	Page #	Descriptions
Material Assistance	6	Please submit file for referral if the child cannot afford one or more of the following: 3 meals a day, school fees, visit to the doctor or medicine, clothes, toiletries, school equipment, and shoes.
Grants & ID Documents	6	Please submit file for referral if the child is not receiving grants or are in need of ID documents.
Suicidal Tendencies	7	Please submit file for referral if the child reported any tendencies or wishful thinking of suicide (i.e. if the child answers "yes" to one or more of the "suicide" questions).
Traumatic Events	8 & 9	Please submit file for referral if the child reported event(s) that was considered traumatic for him/her on the road of life.
Sexual & Physical Abuse	13	Please submit file for referral if the child reported current or past event(s) of sexual or physical abuse.
Home-Based Carer	16	Please submit file for referral if the child's household are in need of a home-based carer.
Medical Attention	17	Please submit file for referral if the child is in need of medical attention , but are not currently receiving help (i.e. if child was raped within 72 hours of interview).
Post-Traumatic Stress Disorder	14-15	Please submit file for referral if the child on average reported high frequency (i.e. on average responded either "most" or "all the time") to one of the re-experiencing symptoms (i.e. question # 1, 2, 3, 4, 5, 10, 11, or 14), three avoidance/numbing symptoms (i.e. question # (7 or 13), 8, 9, 12, 22, 23, 24, 25), and two hyperarousal symptoms (i.e. question # 16, (6 or 17), 15, 13, 18, (19 or 20 or 21)).
Other Clinical Symptoms	7,10, 13, & 21	Please submit file for referral if the child on average reported high frequency (i.e. on average responded either, "yes", "most", or "all the time") to "What I think and feel", "Nervous & Anxious", "Stigma", or "Delinquency" items.

Referral letter for health and mental health

UNIVERSITY OF OXFORD
Department of Social Policy and Social Work
BARNETT HOUSE, 32 WELLINGTON SQUARE,
OXFORD OX1 2ER, ENGLAND.
TEL 01865 270326 FAX 01865 270324



Dear Sir or Madam:

02/02/2012

The following child was interviewed on **17/01/2012** and the interviewer noted that he/she might be in need of **medical and mental health services**. The following particulars were noted:

Name of child: LM

Age: 15

Caregiver: Happiness (biological mother)

Address: On the dirt road behind Funindlela, turn right on the first corner, family lives behind the big brick house

Presenting problems:

-child was raped by two different relatives when she was 9 and again when she was 13. She was taken to the hospital both times for post-exposure prophylaxis.

The child and her caregiver report that the child is unable to hold her urine since the rape in 2010. Whenever the child feels the need to go to the toilet she has to go immediately, otherwise she will wet herself. Please query whether this is an organic problem or psychosomatic. The child also suffers from extreme post-traumatic stress and is underperforming in school

Current conditions:

- the child lives with mother and younger siblings

We request that this would be allocated to your personnel for further investigation. Please provide assistance to the child if possible. Thank you for your collaboration with Young Carers. We appreciate your passion, heart, and hard work in helping the children. If you need more information, please contact me using the details below.

Kind regards,
Franziska Meinck
Project Manager
Cell: (083) 8647858



The Young Carers Project South Africa is a research collaboration between the South African Government and a number of universities and non-governmental organizations. For this research project our interviewers travel from house to house in selected areas to interview children in order to learn more about their daily lives, experiences and feelings. The data collected in this project will be used to assist government in developing social policies relating to children.

Follow-up referral letter for social work and health services

UNIVERSITY OF OXFORD
Department of Social Policy and Social Work

BARNETT HOUSE, 32 WELLINGTON SQUARE,
OXFORD OX1 2ER, ENGLAND.
TEL 01865 270326 FAX 01865 270324



Dear Sir or Madam:

03/05/2012

The following child was re-interviewed on **13/03/2012** and the interviewer noted that he/she might be in need of **home based care and social work services**. The following particulars were noted:

Name of child: BM

D.O.B: 10/1/1997

Name of guardian: Miriam (biological mother)

Address: Stand no xxx Vodacom Park, on top of the hill, Matsulu C.

Phone number: 0XXXX

School: XXX Primary, Grade 7

This is a final referral for BM, a 15-year-old female in extremely urgent need of help from Matsulu social services.

BM is in the later stages of AIDS and is also infected with TB. She is struggling with compliance on her medications with no support at home. BM was first referred to this office in July 2011 and was urgently referred a second time because she was seriously ill in September. When Njabulo met her, she agreed that she needed better support than BM mother was willing to give and agreed to move her. However, she later spoke to BM mother, at which point she decided that the move was not necessary. The same day, BM was admitted to Themba Hospital for very severe military TB. When she was discharged, she was initiated on ARV's, but her mother has not supported her in taking them. Her mother has never been to a clinic appointment. BM and her mother were then referred to the supervising social worker at Matsulu for adherence support, but no one has done an assessment with them or met with the family, and no counseling or further action has been done in spite of continuous, urgent referrals from the Young Carers Project and Rob Ferriera Hospital. Without urgent support from social services, BM is going to be dead within six months. This death could easily be prevented if someone was supporting BM in taking her medication and attending clinic and hospital visits regularly.

BM has no support in taking her medication. Her mother is non-cooperative and



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often away from the house, and BM does not have enough food at home. BM's mother is also HIV+, but she refuses to initiate treatment in spite of having promised BM that she will. Without support from social services, BM is going to die before the end of the year.

We have been referring this child to your office for almost a year and the case has yet to be followed up on. We refuse to stand by and watch BM die because of negligence.

If you need any more information, please do not hesitate to contact us.

Sincerely,

Franziska Meinck and Julia Rosenfeld
Young Carers Project Managers
Cell: (083) 8647858



The Young Carers Project South Africa is a research collaboration between the South African Government and a number of universities and non-governmental organizations. For this research project our interviewers travel from house to house in selected areas to interview children in order to learn more about their daily lives, experiences and feelings. The data collected in this project will be used to assist government in developing social policies relating to children.

Appendix 6 Dissemination

Example letter to request dissemination appointment

DEPARTMENT OF SOCIAL POLICY AND INTERVENTION

Barnett House, 32 Wellington Square,
Oxford, OX1 2ER, United Kingdom
www.spi.ox.ac.uk



To

Mpumalanga Provincial Police Commissioner

Via Fax: 0867549093

White River, 03/07/2012

Request to present research results of the Young Carers Study

Dear Sir,

The Young Carers Study (www.youngcarers.org.za) is the first large scale study to interview a random community sample of 6000 children across South Africa in collaboration with the National Departments of Basic Education, Social Development, Health and Agriculture in order to investigate challenges for children re. health, abuse, mental health, education, and service provision. 1700 of these children were interviewed in Ehlanzeni District.

We have some very interesting data regarding risk factors for delinquency, but more importantly regarding prevalence of abuse and access to police services for victims of these crimes which I think SAPS might benefit from.

I would like to present these findings to you at your convenience or request permission to send you our research report.

Kind regards,

A handwritten signature in blue ink, appearing to read 'FM', is placed above the typed name.

Franziska Meinck
Project Manager Young Carers Project Mpumalanga
Centre for Evidence-Based Interventions
32 Wellington Sq, Oxford OX1 2ER
Email: Franziska.Meinck@spi.ox.ac.uk
Tel: 083 8647858

List of all the occasions when findings from the study were disseminated

Community

23/07/2011 *Community Meeting Matsulu C, South Africa. Dissemination presentation on mental and physical health and abuse.* Matsulu

25/06/2011 *Community Meeting Ceko's village, South Africa. Dissemination presentation on mental and physical health and abuse.* Timbavati

23/06/2012 *Community Meeting Matsulu C, South Africa. Dissemination of research findings.* Matsulu

24/06/2012 *Community Meeting , Tintswalo, South Africa. Dissemination presentation on mental and physical health and abuse.* Acornhoek

Government and Professionals

14/07/2011 *Circuit Manager and all principals of Nkululeko District. Presentation on mental health, physical health and educational outcomes,* Matsulu.

26/08/2011 *Ward Counsellor and Public Relations Officer Meeting of Kanyamazane.* Presentation on mental and physical health and abuse. Kanyamazane

11/10/2011 *Children's Desk at the Mpumalanga Premier's Office, South Africa. Advisory presentation on mental health, physical health, educational and abuse risk for Mpumalanga Policy Framework on the Coordination and Advancement of Children's Rights and Equality.* Nelspruit.

01/11/2011 *Public Relations Officers Meeting, South Africa. Presentation on mental and physical health and abuse.* Nelspruit.

01/11/2011 *Mkhumibini Primary School, South Africa. Teacher's meeting. Presentation on mental health, physical health, abuse and educational outcomes,* Cork, Mkhuhlu.

07/11/2011 *Circuit Manager of Bohlabela District, South Africa*. Presentation on mental health, physical health, abuse and educational outcomes, Mkhuhlu.

07/11/2011 *Thwasani Primary School, South Africa*. Presentation on mental health, physical health, abuse and educational outcomes, Ronaldsey, Mkhuhlu.

09/11/2011 *Magwagwaza High School, South Africa*. Presentation on mental health, physical health, abuse and educational outcomes, Timbavati, Acornhoek.

23/03/2012 *Mental Health Outpatient Unit, Rob Ferreira Hospital, South Africa*. Advisory presentation on the mental health risks for children. Nelspruit.

28/03/2012 *Mpumalanga Mental Health Summit, South Africa*. Child and Adolescent Mental Health Commission. Advisory presentation on mental health risks for children. Nelspruit.

19/04/2012 *Children's Desk at Mpumalanga Premier's Office, South Africa*. Advisory presentation on the outcomes of child abuse. Nelspruit.

24/04/2012 *Ehlanzeni District Municipality, South Africa*. "Planning for Champions", Training Stakeholders for Children's Issues. Advisory presentation on mental health, physical health, abuse and educational outcomes. Nelspruit.

25/04/2012 *Bushbuckridge Municipality, South Africa*. Bushbuckridge HIV/AIDS Strategic Review Workshop. Advisory presentation on physical health, emotional health, abuse and educational outcomes of children affected by HIV. Hazyview.

26/04/2012 *Ehlanzeni District Municipality, Nelspruit*. Sensitization Workshop for the Portfolio Committees of Social Development. Advisory presentation on physical health, mental health, abuse and educational outcomes for vulnerable children. Nelspruit.

09/05/2012 *Ehlanzeni District Social Cluster Meeting*. Advisory presentation on "Health, education and abuse of children affected by HIV/AIDS", Nelspruit.

15/05/2012 *Yezingane Network Mpumalanga Provincial Meeting*. Advisory presentation on "Health, education and abuse of children affected by HIV/AIDS", Kabokweni.

28/05/2012 *2nd Ehlanzeni District AIDS Council Legkotla*. Advisory presentation on "Health, education, abuse of children affected by HIV/AIDS and implications for policy", White River.

06/06/2012 *Ehlanzeni District Department of Health*. Advisory presentation on "Health, education and abuse of children affected by HIV/AIDS", Nelspruit.

07/06/2012 *Mpumalanga Mental Health Society*. Dissemination presentation on "Mental health, education and abuse of children affected by HIV/AIDS", Nelspruit

15/06/2012 *Nkululeko Circuit Principals*. Dissemination presentation on "Health, education and abuse of children affected by HIV/AIDS", Kaapmuiden.

19/06/2012 *Barberton Hospital Health Care Professionals*. Dissemination presentation on "Health, education and abuse of children affected by HIV/AIDS", Barberton.

19/06/2012 *St. John's Mission for AIDs affected children*. Dissemination presentation on "Health, education and abuse of children affected by HIV/AIDS". Barberton.

20/06/2012 *Bushbuckridge NPO meeting*. Dissemination presentation on "Health, education and abuse of children affected by HIV/AIDS". Dwarsloop.

22/06/2012 *Mpumalanga Provincial Government, DoH, DBE and DSD*. Dissemination presentation on "Health, education and abuse of children affected by HIV/AIDS", Nelspruit.

26/06/2012 *Children's Desk at Mpumalanga Premier's Office, South Africa*. Advisory presentation on impact of social protection on risks for children. Nelspruit.

03/07/2012 *Matsulu Council Plenary meeting for World Population Day*. Advisory presentation on risky sexual behaviours of children, HIV and teenage pregnancy. Matsulu.

05/07/2012 *Nkangala District AIDS Council Workshop*. Advisory presentation on “Health, education and abuse of children affected by HIV/AIDS”, Middelburg.

10/07/2012 *Deputy Commissioner of Mpumalanga Police*. Advisory presentation on help-seeking behaviours of abuse survivors. SAPS, Nelspruit.

Media:

19/03/2012 Lodrick Ndhlovu and Lydia Ngomane were on Bushbuckridge Radio talking about the research findings (in XiTsonga).

18/03/2012 Julia Rosenfeld on SAFM weekend pm live with Sisanda Jonas at 815pm

Policies:

“MPUMALANGA POLICY FRAMEWORK ON THE COORDINATION AND ADVANCEMENT OF CHILDREN’S RIGHTS AND EQUALITY” Office of the Premier, Office on the Rights of the Child, Mpumalanga Provincial Government

Appendix 7 Reports and summaries of results

Community feedback sheet

**social development**
Department of Social Development
REPUBLIC OF SOUTH AFRICA

**health**
Department of Health
REPUBLIC OF SOUTH AFRICA

**agriculture,
forestry & fisheries**
Department of Agriculture, Forestry & Fisheries
REPUBLIC OF SOUTH AFRICA

**basic education**
Department of Basic Education
REPUBLIC OF SOUTH AFRICA



Young Carers Project South Africa: Feedback Sheet

The Young Carers Project is a multi-agency collaboration between the University of Oxford, the South African Government and the Universities of Cape Town, KwaZulu-Natal and Witwatersrand. The project is to understand what children in South Africa need, what services they are getting, and what can help them with their development and education.

The project has interviewed 6000 children and 2500 of their caregivers in 6 sites in the provinces of Mpumalanga, Western Cape and KwaZulu-Natal. All results are reported to the government and NGOs. This year we are coming back to speak to children again, and this feedback sheet reports what we have found and done so far. For more information please visit our website www.youngcarers.org.za

Some of the challenges children said they are facing in South Africa today:

- Living in a family with a sick carer
- Worrying about a sick person at home
- Not being able to afford school fees and books
- Not having enough to eat
- Being bullied in the community and in school
- Not being able to concentrate in school because of hunger or worry
- Dropping out of school because of orphanhood or caring tasks at home
- Being bullied, being orphaned, being physically, emotionally or sexually abused, or worrying about a sick carer can cause sadness, anxiousness and depression

Some of the things that help children in South Africa

- Receiving a child support or foster care grant
- Having a healthy carer
- Doing activities like sports and games
- Having support from friends and family
- Having support from the community
- Receiving appropriate health care services

Some of the things you can do to help:

- Ensure all children living in a household with TB get tested and treated if necessary
- Talk to children and young adults about their worries
- Help orphaned and vulnerable children access financial help they need and ensure they will benefit from it
- Stop physical, sexual and emotional abuse when you see it happening
- Talk to young people about responsible sexual behaviours and ways they can protect themselves from HIV/AIDS
- Protect youths from forced sexual intercourse
- If you see bullying, intervene!

Who did we tell what you told us?

- National Department of Social Development
- National Department of Health, cluster Maternal and Child Health and Nutrition
- National Action Committee for Children Infected and Affected by HIV and AIDS (NACCA)
- Department of Basic Education
- UNICEF Southern Africa

These policies were changed because of what you said:

- Schools Safety Policy (Department of Basic Education)
Development of psychosocial support guidelines for Home and Community-Based Caregivers (Department of Social Development)
- National Action Plan for Children Affected by HIV and AIDS (NACCA, Department of Social Development, Department of Health, Department of Basic Education)
- Development of support groups for AIDS-affected children (Department of Social Development)
- Life skill Programme for Youth Headed Households



Results report to the Mpumalanga government



HIV, abuse, health and poverty: challenges for children in Mpumalanga

2012

Background

Children and adolescents living in resource constrained environments are often burdened by poverty, care demands and health concerns. This report summarises the findings of a major new community-based study in Mpumalanga exploring the challenges children face within the province. The results of this study can contribute to policy to improve children's life circumstances.

This policy brief reports on the results from interviews with 1638 children between June 2011 and June 2012 in Ehlanzeni District, Mpumalanga. This was a follow-up of 1672 children interviewed the previous year. The children were recruited using door-to-door sampling. At the time of the second interview the children were aged 11 to 18 years. Children were originally interviewed within Bushbuckridge and Mbombela Municipalities. Interviews took place in schools and at children's homes or safe places within the community. Children filled in a one hour questionnaire guided by local community interviewers specially trained in working with vulnerable children.

Summary of findings

The group comprised 710 boys and 863 girls. The average age was 13.5 at time of recruitment. All findings were tested for gender differences. Where there were no differences, the results for boys and girls are shown together. Similarly, when there are no differences between urban and rural populations, these results are shown together.

GRANTS AND SUPPORT

Birth Certificates and Government Support

Although the right to a name and identity at birth is a constitutional right for all South Africans, this study reveals that nearly one in twenty children (4.4%) do not have a birth certificate. Research has indicated that receiving grants is associated with decreases in mental and physical health problems, delinquent behaviour, and engaging in risky behaviour (Cluver, forthcoming).

Grants overall - The results show that 27% of households are not receiving any grants. The sample was drawn from deprived families in high poverty areas.

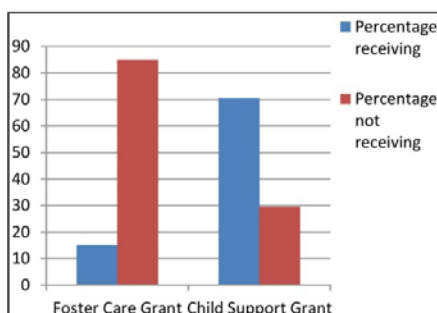
Foster Care Grant - Of those children interviewed who are double orphans, 85% are not receiving a foster care grant. Within the sub-group of AIDS-orphaned children 89.4% are not receiving a foster care grant.



Child Support Grant – Nearly a third of

interviewed households are not receiving child support grants, despite eligibility. The reasons for this are varied. Children must have a birth certificate in order to obtain a grant. The absence of this document, as well as other necessary documents (such as ID), is the main factor associated with children not receiving a Child Support Grant in this study. However our research also shows that 27.3% of children who have a birth certificate are still not getting a Child Support Grant. Some reasons mentioned were: the absence of other relevant documents 13.4%, waiting for the social worker to make an assessment 5.8%, parents work for government 8.3%, couldn't afford transport to the grant office 4.1%, it was cut 2%, or being sent away by the Grant Office without knowing the reason 4.7%. The majority of the children without a grant do not know why they are not getting it 34.4%.

Figure 1 - Government Support Statistics for those in need



Food Aid

Food Parcels – 92.2% of participants never have access to food parcels, and only 1.4% receive regular food parcels (6.4% receive food parcels which are unreliable).

Figure 2 - Reliability of Food Aid



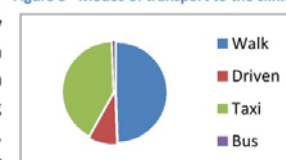
Drop-in Centres – 99.3% of participants do not have access to a soup kitchen or drop-in centre and only 0.1% regularly receive food from one of these sources. The remaining 0.6% sometimes access soup kitchens or drop-in centres.

Distance From Services

Distance From Clinic – Many children live far from the clinics. Children

use multiple forms of transport to the clinic including walking (49.5%), driving (8.6%), taxi (41.4%) and the bus (0.6%). Overall, 4.7% of children report that the distance to their clinic was over 60 minutes. 3.5% of children living in a rural area have to travel more than 60 minutes to their clinic, as opposed to 1.5% of children living in an urban area.

Figure 3 - Modes of transport to the clinic



Distance From Water Tap – Running water is not freely available for all within the homesteads. Overall, 49.1% have to travel to get to their water. 4% of children living in a rural area have to travel over 60 minutes to their water tap as opposed to none living in urban areas.

SEXUAL HEALTH AND HIV TESTING

Condom Use – 57.1% of sexually active participants inconsistently or never use a condom.

Teen Pregnancy – The study reveals that 2.6% of participants reported a teen pregnancy (girls) or have made someone pregnant (boys). Of those that have been pregnant or made someone pregnant, 41.5% had been sexually abused (24.4% of those who disclosed rape had been pregnant at one time). This difference between those who had been sexually abused and those who had not regarding teen pregnancy is significant ($p < 0.001$). Of those who were pregnant or made pregnant 36.8% never used a condom.

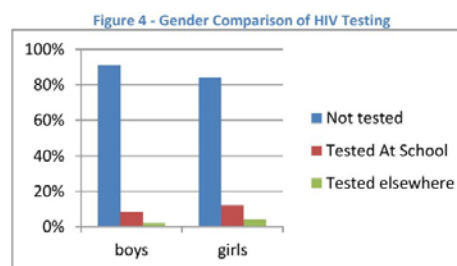
HIV Testing Rates (How many kids were tested for HIV)

Prevalence of HIV Testing – HIV testing uptake is low - 86.9% of children interviewed have never tested for HIV.

Of the 12.7% that have been tested: 79% were tested at school and 21% were tested elsewhere. Of these, 8.6% of children tested positive, 22.8% were tested but are unsure of the results, 58.3% tested negative and 10.2% were tested but were not willing to disclose the results.

Urban and Rural differences – Children are more likely to test in rural (85.1% not tested) than in urban areas (88.6% not tested) ($p = 0.012$). Within those who were tested, more urban responders (10.3%) tested positive than rural responders (8.3%).

Gender – The results show that boys are less likely to test for HIV than girls. More boys are not tested (91.1%) than girls (84.7%). Of the subgroup that was tested for HIV, 5.6% of boys and 10.9% of girls tested positive.



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HOUSEHOLD HEALTH AND POVERTY

Health of Household (how many children are living with a chronically ill person affected by HIV or other illnesses)

Many children are living in a household with a sick person; 32.5% of households interviewed contained at least one sick person. Of the households containing sick people, 89.9% contained 1 sick person, 8.9% contained 2 sick people and 1.2% contained 3 sick people. The findings reveal that overall, 12.8% of households contained a person sick with AIDS. Within the subgroup of households containing at least 1 sick person, 39.4% contained someone sick with AIDS.

Tuberculosis

Children with TB – The results show that 3.8% of children have had 3 +TB-related symptoms. Out of all participants with 3+ TB-related symptoms, 96.9% had never been tested for TB.

Food Insufficiency and Hunger Scale (food insufficiency in home and hungry at school)

Children's Experience of Two+ Days without Food – The findings reveal that 10.5% of children experienced an average of two or more days without food in the past week. Of those experiencing food insufficiency 30.3% are not receiving grants. 69.7% of children who are experiencing food insufficiency are from a rural area. Experience of food insufficiency is more likely in rural than urban areas ($p<0.001$). Rural living and the absence of grant support is clearly contributing to child hunger.

Children's Hunger at School and at Home – In addition to measuring days without food, we asked children to describe an overall rating on hunger frequency. Overall, 12.2% of children go to bed hungry 1 night or more a week and about one in five children (21.8%) said they were sometimes, often or always hungry at school. Hunger at school may impede access to education; of those who experience concentration problems in school 31.9% report being hungry in school.

Poverty (not able to afford basic needs)

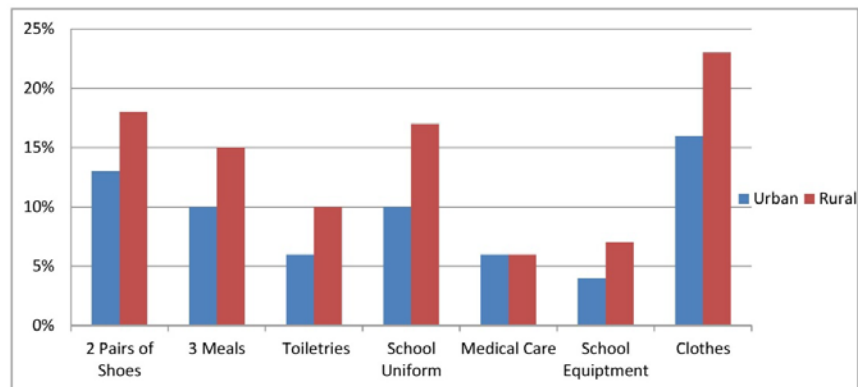
In this study we looked at eight different aspects of poverty. We then used a measure of "Ability to Afford Three or More Necessities" to compute an overall poverty value. This value shows us that only 18.1% of households can afford three or more necessities. Within those who cannot afford three or more necessities, 50.3% came from urban areas ($p<0.001$).

Three of the eight separate aspects of poverty are set out below:

Afford 2 Pairs of Shoes – The results show that 15.6% of children can not afford 2 pairs of shoes. Children living in urban areas are less likely to be able to afford two pairs of shoes - 12.8% in rural areas are unable to afford this, compared to 18% in urban areas ($p=0.05$).



Figure 5 - Breakdown of Necessities which families are NOT able to afford



Afford 3 Meals – The results show that 12.7% of households can not afford 3 meals a day. Those living in a rural area are more likely to not be able to afford 3 meals a day (14.8%) as opposed to those living in an urban area (10.4%).

Afford basic Toiletries such as soap – The results show that 8.1% of households can not afford toiletries. Those living in a rural area are more likely not to be able to afford toiletries (9.7%) than those living in an urban area (6.3%).

STIGMA AND CHILD PSYCHOLOGICAL DISTRESS

Stigma (AIDS-related stigma)

The questionnaire asked a set of eleven questions to determine the general effect of AIDS-related stigma on the participants. These questions included home and community-based and school-based stigma and were with reference to a sick or dead family member. 18.1% of all children reported experience of AIDS-related stigma. Experience of stigma is more likely in the urban setting, with 58% of all participants who experienced stigma coming from urban areas ($p=0.075$). There is no significant difference between the stigma experienced between boys and girls. Of those reporting AIDS-related stigma 20.8% are living with at least one person unwell with AIDS and 29.9% are orphaned by AIDS ($p<0.001$).

Child Depression

This study included a standardised depression scale (CDI) – a validated depression inventory. Scores above the cut-off point indicate a clinical level disorder and a need to be referred to a mental health professional. Overall 25.5% of children reported at least one symptom of depression and 4.8%



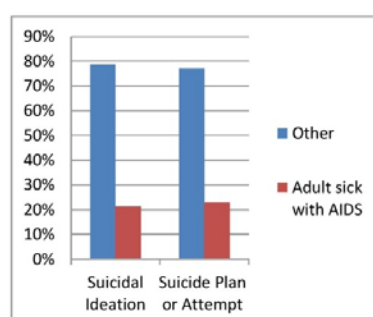
scored above the cut off point for referral. The majority of children within those suffering from depression are from an urban area (56.7%; $p=0.002$). Additionally, of those that are depressed, 34.8% have at least one person in their household sick with AIDS. This difference in depression levels between those who do and do not have a person in their household who was sick with AIDS is significant ($p=0.005$).

Child Anxiety

Participants showed an overall high level of anxiety (using the Revised Children's Manifest Anxiety Scale). Those on or above the cut-off on this scale need to be referred to a mental health professional. Overall, 6.1% of children are on or above the cut-off for referral on the RCMAS scale. We also found that 75.5% experience at least one symptom of anxiety. Of those who are experiencing anxiety, 88.1% have at least one person in their household sick with AIDS ($p<0.001$).

Suicide- (Suicidal thoughts and attempted suicide)

Figure 6 - Expressions of Suicide Breakdown



Suicidal Ideation – The study has shown that 12.5% of participants are experiencing suicidal ideation. The majority of children experiencing suicidal ideation within this sample were from rural areas (56.3%; $p=0.004$). Within those who disclosed suicidal ideation, 21.3% have at least one person in their household sick with AIDS ($p<0.001$).

Suicidal Plan or Attempt – Overall 5.3% of participants disclosed that they have a suicidal plan or have attempted suicide. Children living with at least one person sick with AIDS in their household are more

likely to have a suicidal plan or to have attempted suicide ($p=.005$). 22.9% of these children had suicidal thoughts.



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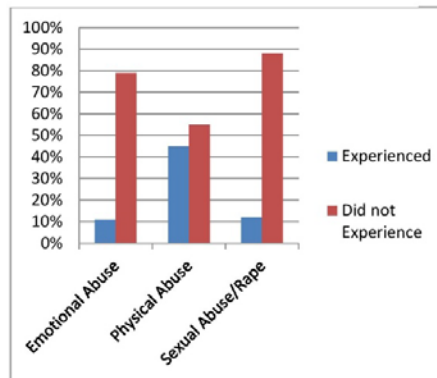
Abuse in the Past Year from Caregivers or Adults

Overall the data reveals a very high percentage of abuse. This figure, however, may be an underestimate of the total abuse experience due to issues of underreporting which are common with abuse survivors.

Emotional Abuse – A set of UNICEF

questions were used to determine amount of emotional abuse the children were exposed to (i.e. regularly and intentionally being called lazy and stupid, being made unwelcome in the home, experiencing threats to invoke ghosts, being threatened to be sent away). The results revealed that 10.8% of children experience weekly emotional abuse, with 1.1% experiencing intentional neglect. Of those who are experiencing weekly emotional abuse, 55% live in a rural area and 44% live in an urban area. Additionally, of those that are abused weekly, 27.6% have at least one person in their household sick with AIDS ($p < 0.001$).

Figure 7 - Abuse Experience



Physical Abuse- Overall, 44.6% of children are physically abused (i.e. hit with an object likely to cause harm, hit hard enough to leave lasting marks, having their ears or hair pulled, or having meals withheld specifically as punishment). Prevalence of weekly severe physical abuse is 5.7%. The majority of children who reported physical abuse reside in an urban area (53%) whereas the majority of children who report severe physical abuse reside in a rural area (72%, $p < 0.001$). 15.8% have at least one person in their household sick with AIDS ($p = 0.002$).

Sexual Abuse or Rape – Children reported an exceedingly high level of exposure to sexual abuse (12.6%) or rape only (1.9%). Within this group, children from rural areas were more likely to report rape (55%) and more likely to report sexual abuse (64%, $p < 0.001$). Of the children who were sexually active, 12% reported having been forced to have sex. Of those who experience sexual abuse or rape, 17.4% have at least one person in their household sick with AIDS ($p = 0.04$).

Girls Experience of Sexual Abuse and Rape – Girls are subject to a much higher percentage of sexual abuse ($p < 0.001$) and rape ($p = 0.007$) than boys. The overall rape prevalence within females in this sample was 3.3%. Of the children who reported forced sex 80.8% are girls, and of those who have experienced sexual abuse, 66.7% are girls.

The study found that emotional, physical and sexual abuse is more common for rural residents, All types of abuse are increased by the presence of HIV and AIDS in the household.



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Domestic Arguments and Violence

Household Arguments with Adults Shouting/ Domestic Arguments – 12.5% of children report that there have been household arguments with adults shouting in the last week.

Adults Hitting Each Other at Home/ Domestic Violence – 4.5% of children report that there have been adults hitting each other at home in the past week with significantly higher numbers in urban areas (70.5%, $p < .001$).

Bullying

In this study we measured bullying using a set of questions addressing different kinds of physical and emotional bullying. We found that 72.9% of children experience at least one incident of bullying i.e. name calling and swearing, having possessions stolen, or being made fun of. The highest incidence of bullying is experienced within the school environment (34.1%).



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Appendix 8 Questionnaires

Baseline questionnaire



TEEN TALK SOUTH AFRICA

Whatever you say is confidential. This means we will not report your real name.

Please write your name here:

.....

Now, please think of a different name which we can use when we are writing about this research. You can pick any name you want!

.....

Questionnaire number: Boy/Girl

Place of interview: P #:

School/org: Grade:

ID number:

Interviewer: Date:

Enumeration Area Number:

GPS latitude (S): S ° . ‘

GPS longitude (E): E ° . ‘

EMIS #:

Privacy code:

Would you mind if we contacted you again? Please write your address and telephone number so we can get back in touch:

Address:

.....

.....

Telephone:

YoungCarers
PROJECT SOUTH AFRICA

This is not a test. There are no right or wrong answers! This research aims to help young people in South Africa. Thank you for taking the time to help.

TEEN TALK SOUTH AFRICA

Please take time to read this sheet carefully and decide whether you do or don't want to take part. Ask the research team if there is anything that is not clear or if you have questions. Thank you for reading this.

What is this study about? This study is about young people and their feelings about their lives. The government wants to know more so they can plan how to help young people and families better.

Do I have to take part? Not at all. It is up to you to decide whether or not to take part. If you do not want to, this will not affect any help you may be getting from anyone. You will not get in any trouble if you do not want to take part.

If you decide to take part, you are still free to stop at any time. You don't have to give a reason. Again, this will not affect any help or support you are getting from anyone. In one year's time, we will visit you again to see how you are doing. You can choose then whether you want to talk to us again!

What would I have to do? If you decide to take part, you will first sign a consent form (on the next page), and then spend about an hour talking together and doing activities with a researcher.

What if the questions upset me? You can stop at any point, and you do not have to give a reason. You can also contact the research team at any point after the group, and say that you want your answers about certain questions to be destroyed, which we will do straight away. If you want to talk to someone about anything that has come up from this, you can tell one of the researchers or contact the Young Carers Team at Cape Town Child Welfare (021 638 3127).

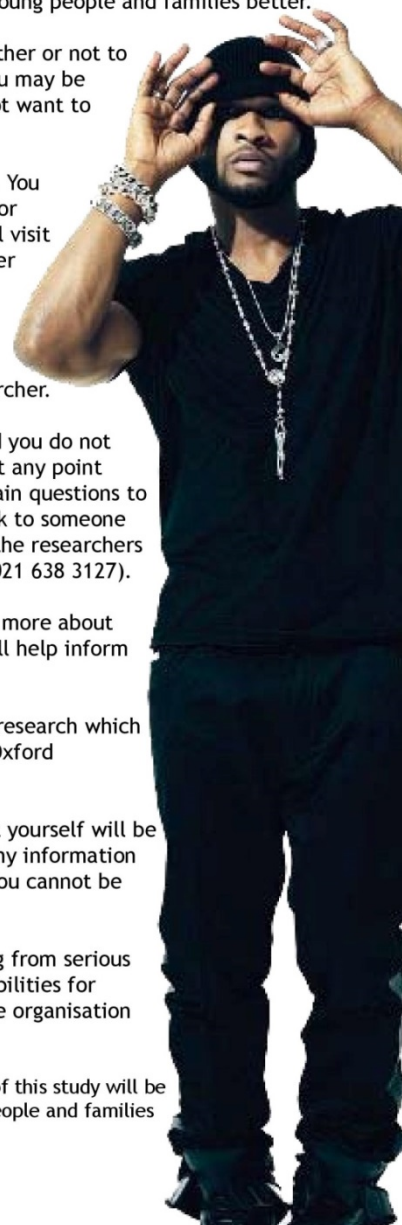
Why should I take part in this study? This may help us to know more about what can help young people in South Africa. What you tell us will help inform future government policy.

What if I have a complaint? If there is anything to do with this research which you are unhappy with, you can complain to Dr. Lucie Cluver at Oxford University (lucie.cluver@socres.ox.ac.uk).

Will what I say be kept confidential? Anything you tell us about yourself will be kept strictly confidential, and will not be told to anyone else. Any information about you would have your name and address changed so that you cannot be recognised from it.

But during this study, it may become clear that you are suffering from serious difficulties. If so, the interviewer will explain to you some possibilities for further help. If there is a safety issue, we may contact a welfare organisation for you. All this will be talked over with you first.

What will happen to the results of the research study? The results of this study will be used to help the government and others to make policies for young people and families in situations much like yours.



Who is organising and reviewing the research? The research is being organised by the University of Oxford in England, the University of Witwatersrand, the University of KwaZulu-Natal and is being tested by the University of Cape Town. The research is also organised by The Department of Social Development, the Department of Health and the Department of Education in Pretoria. Ethics groups in both countries have approved the research. If you have any complaints about ethics in the Western Cape, please contact the UCT Health Sciences Research Ethics Committee (E52-23 Old Main Building, Groote Schuur Hospital, Observatory, 7925). If you have any complaints in Kwa-Zulu Natal, please contact the University of Kwa-Zulu Natal Research Ethics Committee - telephone: (031) 260 3587. If you have any complaints in Mpumalanga or in Gauteng, please contact the University of Witwatersrand Research Ethics Committee - telephone: (011) 717 71234.

Contact for further information: Dr Lucie Cluver, Cape Town Child Welfare, Lower Klipfontein Road, Gatesville, Athlone, South Africa 8000
Email: lucie.cluver@socres.ox.ac.uk

Thank you for reading this sheet. If you feel comfortable with everything, you can fill in the box:

Do I want to take part?

Tick:

1. I have read and understand the information sheet for this study and have had the chance to ask questions
2. I understand that I have chosen to take part and that I am free to stop at any time, without giving any reason. This will not change any support or help I am getting
3. I agree that any words I may say during the interview can be used, without giving my name, in the presentation of the research. I agree to take part in the study

☐

☐

☐

Sign:

Name of participant

Name of researcher

Signature

Date



Could you give us the names, addresses and telephone numbers of 2 people (who you don't live with) who you think would know how to contact you in a few years time?

1.
.....
.....
.....
.....

2.
.....
.....
.....
.....

3

My house

Please circle the one which is most like your home:

1. house made of brick or concrete



2. hut made of traditional materials



3. shack on its own plot



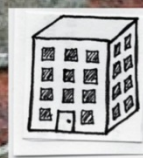
4. living on the street



5. shack in a back yard



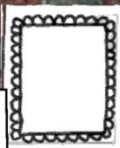
6. block of flats



7. children's home or shelter for kids



8. other (what kind?)



Where do you get your water from?

1: a tap in my house
 2: a community tap that lots of people use (how long does it take you to get to it?)
 3: a river or stream

people looking after other people

Do you have a parent, guardian or caregiver staying with you and taking care of you at home?
 yes no

If you do, please write their name here:
 How old is this person?

Is this person your:

- | | |
|---------------------|--------------------------------|
| Brother | Uncle |
| Stepfather | Neighbour/family friend |
| Grandma | Biological father |
| Sister | Aunt |
| Foster mother | Stepmother |
| Grandpa | Biological mother |
| No-one | Social worker/careworker |
| Foster father | Other (who?) |

P #:

Has your caregiver talked to you about who you will live with if they aren't able to look after you anymore?

..... Yes No

If they have, who will that person be?

4

My day

On a normal weekday, how many hours do you spend:

Sleeping?

At school?

Playing?

Doing homework?

Working for money?

Helping at home/helping with sick people?

Other (what?):

.....



People I live with

How many rooms are there in your home, like a bathroom kitchen and other rooms? Draw them below.

1) Who sleeps in each room? 2) Write down their relationship to you, 3) whether they are a boy or girl and 4) how old they are!

5) Please circle anyone in the house who is sick.

6) Now, could you put a tick next to anyone in the home who has a job? Write down next to them whether it is a regular job (every day) a part-time job (some days each week) or a 'sometimes' job (like just over harvest, or on a building project).

Please answer these questions about stuff that happens at home - just tick the best answer:

	Never	Almost never	Sometimes	Often	Always
Your carer says you have done something well					
Your carer threatens to punish you and then does not do it					
You go out without a set time to be home					
You talk your carer out of punishing you after you have done something wrong					
You stay out in the evening past the time you are supposed to be at home					
Your carer compliments you when you have done something well					
Your carer praises you for behaving well					
Your carer does not know who you are friends with					
Your carer lets you out of a punishment early					
Your carer tells you that they like it when you help out around the house					

Please tick the things which you can afford at home:

☐ 3 meals a day



☐ toiletries to be able to wash every day



☐ school fees



☐ school uniform

☐ school equipment



☐ visit to the doctor when you are ill, and all the medicines you need

☐ enough clothes to keep you warm and dry



☐ more than one pair of shoes

Is the household receiving any grants?

- no grants (XX)
- foster care grant
- child support grant
- pension
- disability grant
- care dependency grant

If you should be getting a grant but aren't, do you know the reason why?

- Didn't have the right documents (ID, birth certificate etc)
- Waiting for a social worker to do an assessment
- Can't afford transport to the grant office
- The grant office sent us away
- Another reason (tell us?)
-
-
- Not applicable

Stuff at home

Do you have an ID book? Yes No
Do you have a birth certificate? Yes No

Sometimes kids don't have enough food in their home. How many days in the past 7 days did you not have enough food in your home?

How many days did you go to bed hungry?

Do you get the same amount of food as other kids in your home?

..... More The same Less



What I think and feel...

This part of the questionnaire looks at sadness and other difficulties which many people experience at some point in their lives. For each group of 3 statements, pick out which best describes how you have felt in the last 2 weeks...

- 1 Nothing will ever work out for me
 I am not sure if things will work out for me
 Things will work out for me OK

- 2 I am sad once in a while
 I am sad many times
 I am sad all the time

- 3 I look OK
 There are some bad things about my looks
 I look ugly

- 4 I hate myself
 I do not like myself
 I like myself

- 5 I do not feel alone
 I feel alone many times
 I feel alone all the time

- 6 I do most things OK
 I do many things wrong
 I do everything wrong

- 7 I have plenty of friends
 I have some friends but wish I had more
 I don't have any friends

- 8 I feel like crying every day
 I feel like crying many days
 I feel like crying once in a while

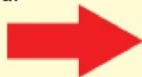
- 9 Nobody really loves me
 I am not sure if anybody loves me
 I am sure that somebody loves me

- 10 Things bother me all the time
 Things bother me many times
 Things bother me once in a while

In the past month did you:

Wish you were dead?
 Want to hurt yourself?
 Think about killing yourself?
 Think of a way to kill yourself?
 Try to kill yourself?

Many kids and teenagers feel nervous or anxious at times. Please say which of these is true for you:



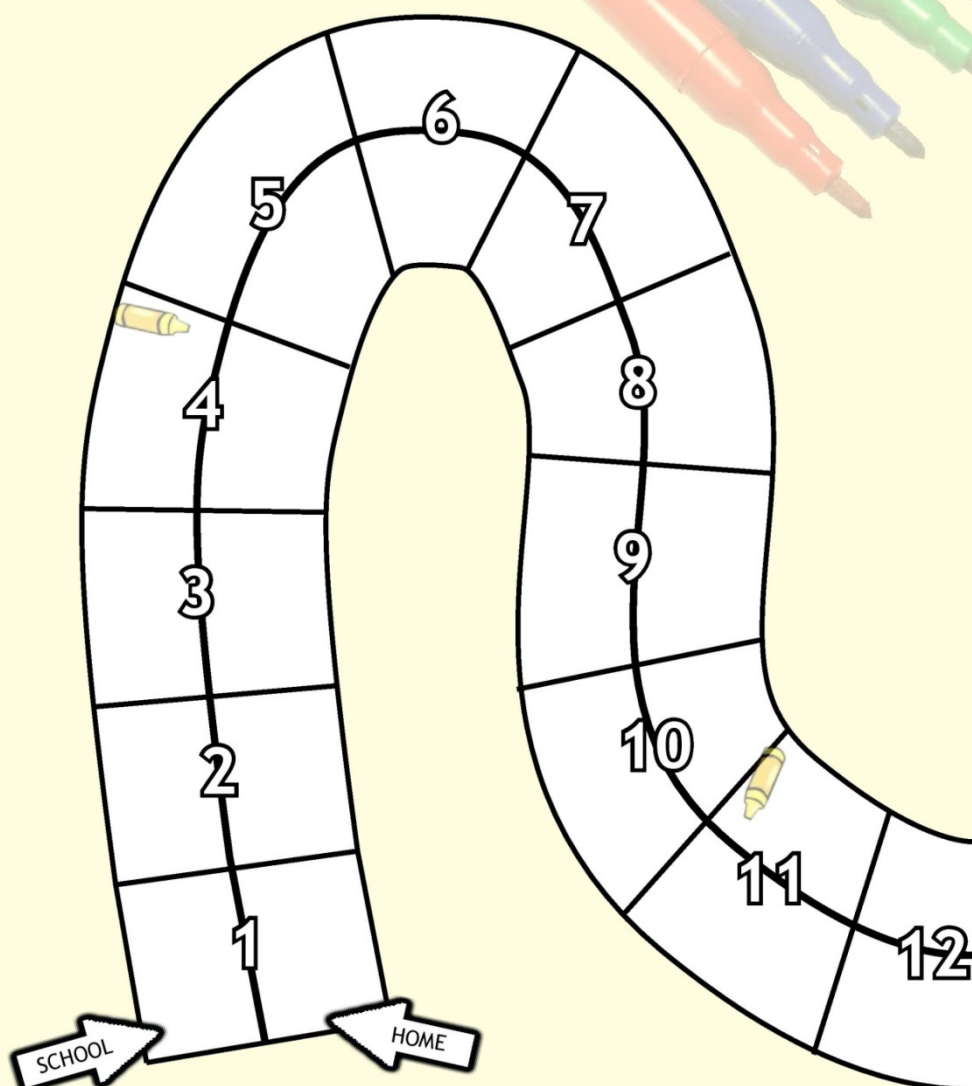
1. I worry a lot of the time	yes	no
2. I worry about what my carers will say to me	yes	no
3. I feel that others do not like the way I do things	yes	no
4. It is hard for me to get to sleep at night	yes	no
5. I worry about what other people think about me	yes	no
6. I feel alone even when there are people with me	yes	no
7. I worry about what is going to happen	yes	no
8. Other children are happier than I am	yes	no
9. I have bad dreams	yes	no
10. I wake up scared some of the time	yes	no
11. I worry when I go to bed at night	yes	no
12. I am nervous	yes	no
13. A lot of people are against me	yes	no
14. I often worry about something bad happening to me	yes	no

7

1: For HOME, write on the road:

- ☐ whose home were you living in?
- ☐ who was the person who looked after you most?
- ☐ why did things change?

my road



START!

I was born on (date)

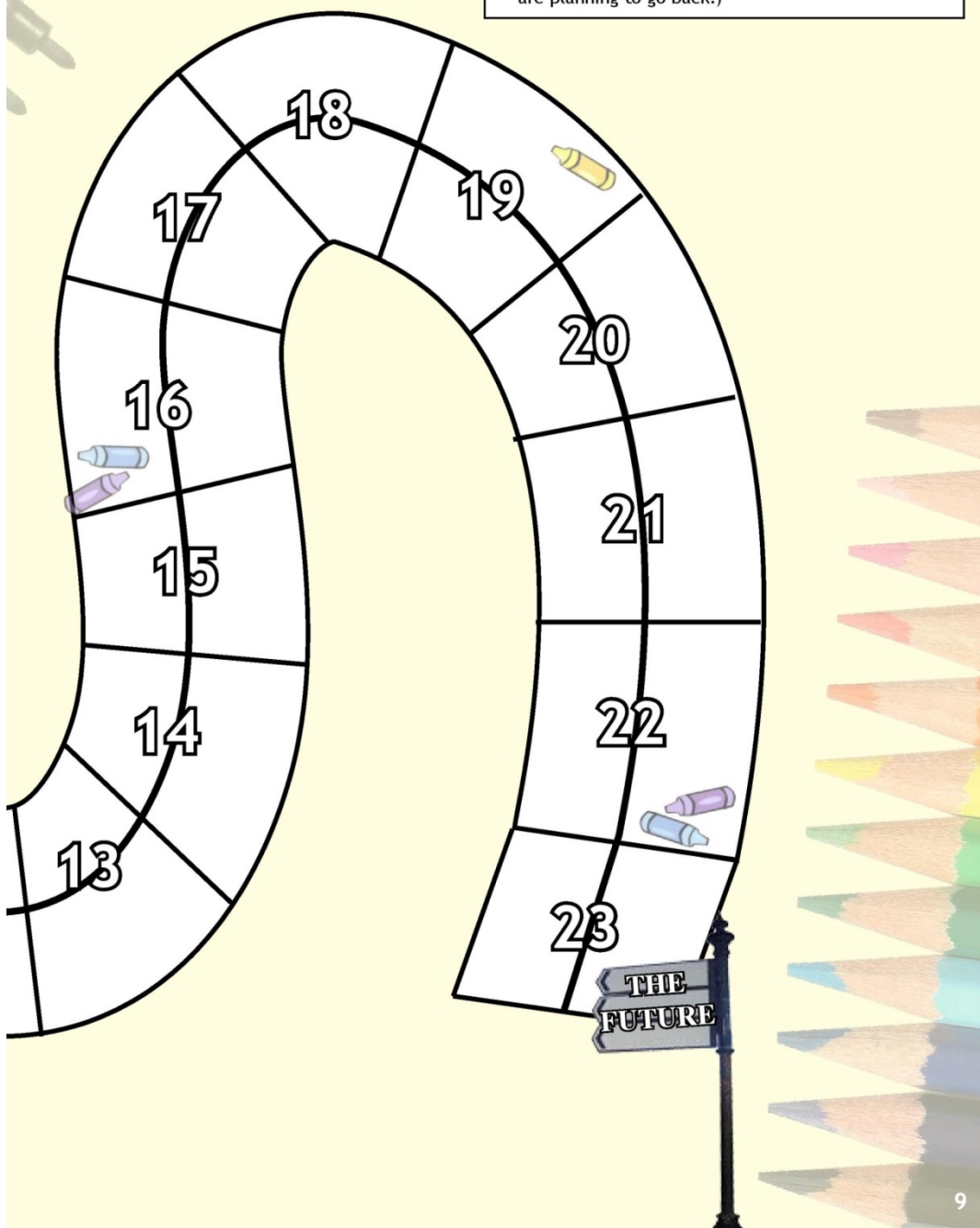
Where?

Who looked after you most?

of life

2: For SCHOOL, write on the road:

- ☐ what grade you are in now
- ☐ what are the names of your schools
- ☐ any years you repeated and why
- ☐ when you left school and why? (also say if you are planning to go back!)



What kinds of support do you get from people in your life?

	This person is a person in my life		This person is helpful when I have a personal problem			This person is helpful when I need money and other things			I have fun with this person		
	yes	no	not at all	sort of	very	not at all	sort of	very	not at all	sort of	very
Your caregiver											
Your sisters or brothers											
A teacher, or the school principal											
A religious leader											
Your best friend											
Your group of close friends											
Other people (tell us who:)											

How about these kinds of help?

And how reliable are they?

	Regular (at least once a month)	Sometimes	Never
A food parcel			
A meal at a soup kitchen			

Has your family had help from a traditional healer with sickness or death?

..... Yes (what kind of help?)

..... No

SUPPORT



Some kids have parents who were ill for some time before they died. Or their parent is unwell at the moment. It's difficult for kids to handle sometimes. Could you say how much these things are true for you?

Because someone in my family is sick or has died...

	Not at all	Sometimes	All the time
I've been teased			
I've been treated badly			
People have gossiped behind my back			
I worry about being rejected			
Parents who know don't want me around their kids			
I avoid making new friends			
I feel different and alone			
If people know, they avoid touching me			
If people know, they are afraid of me			
If people know, they think I am a bad person			

Did this upset you?

..... Not at all

..... Somewhat

..... Very much

Has anyone close to you died? Could you tell us who they were? And when? Do you know what happened? (you can write, or draw them)

CONFIDENTIAL SICKNESS REPORT SHEET

Fill this out only if someone is unwell in the home.

Questionnaire no:

Who is the person who you help look after most?

How old are they?

How long have they been sick for?

In the past month, is this person's health

☐ Very good ☐ good ☐ moderate ☐ bad ☐ very bad

Has this person been happy in the past month?

☐ very happy ☐ happy ☐ ok ☐ sad ☐ very sad ☐ angry

How often in the past month has this person been unwell?

☐ never ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ all month

Thank you for helping us with this. These questions are totally confidential - they will be put in a sealed envelope. Please don't write your name on this sheet.

P #:

When people are unwell, they find it difficult to do everyday things. Could you think about what this person finds hard to do?

	Not at all difficult	A little difficult	Very difficult	Not able to do it
Carrying shopping				
Climbing into a taxi or bus				
Bending or kneeling				
Walking a kilometre				
Walking 100 metres				
Washing or dressing				
Getting out of bed				

Could you tell us what this person is sick with?

XX

- ☐ Have they lost weight and become very thin?
- ☐ Have they got diabetes?
- ☐ Have they had any of these things: very pale, or hair changing colour, or legs swelling up, or burning feelings in their feet, or has their skin been very dry?
- ☐ Do they have emotional problems?
- ☐ Have their eyes been yellow, and they've had a fever? Or itching?
- ☐ Have they had shingles or a rash on their skin?
- ☐ Have they got high blood pressure?
- ☐ Have they had sores on their body?
- ☐ Have they had ulcers or white patches in their mouth, or problems swallowing food?
- ☐ Do they drink alcohol too much?
- ☐ Do they have cancer? Where is the cancer?
- ☐ Have they had trouble breathing, or a cough for more than 2 days with fever?
- ☐ Have they had TB in the last five years?
- ☐ Do they have arthritis?
- ☐ Have they been bewitched?
- ☐ Have they had diarrhoea or a runny tummy for more than 2 days?
- ☐ Do they have HIV?
- ☐ Have they had anything else we haven't asked about? (What do they have?)

CONFIDENTIAL PARENT REPORT SHEET

Fill this out only if a parent has died.

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential - they will be put in a sealed envelope. Please don't write your name on this sheet.

How was this person related to you?

How old was this person when they died?

Do you know what happened?

- ☐ road accident
- ☐ illness - do you know what?
- ☐ attacked
- ☐ something else (Could you tell us?)

How long were they sick for?

Can you get their death certificate when you need it for grants? ☐ Yes ☐ No

XX Could we ask you about some of the symptoms of sickness your parent had before they died?

- ☐ Did they lose weight and become very thin?
- ☐ Did they have diabetes?
- ☐ Did they have any of these things: very pale, or hair changing colour, or legs swelling up, or burning feelings in their feet, or was their skin very dry?
- ☐ Did they have emotional problems?
- ☐ Were their eyes yellow, and they had a fever? Or itching?
- ☐ Did they have shingles or a rash on their skin?
- ☐ Did they have high blood pressure?
- ☐ Did they have sores on their body?
- ☐ Did they have ulcers or white patches in their mouth, or problems swallowing food?
- ☐ Did they drink alcohol too much?
- ☐ Did they have cancer? Where was the cancer?
- ☐ Did they have trouble breathing, or a cough for more than 2 days with fever?
- ☐ Did they have TB in the last five years?
- ☐ Did they have arthritis?
- ☐ Were they bewitched?
- ☐ Did they have diarrhoea or a runny tummy for more than 2 days?
- ☐ Did they have HIV?
- ☐ Did they have anything else we haven't asked about? (What did they have?)

Would you like to draw or write something for your parent?

Stuff that's been difficult for me



Here are Buntu and Lindiwe, telling us some things which many kids in South Africa have experienced. Could you tell us whether these things have happened to you also?



Buntu's family have lots of arguments. Sometimes adults shout at each other and sometimes there is fighting. This last week, how many days were there arguments with adults shouting in your home?

What were these arguments mainly about?

How many days were there arguments with adults hitting each other in your home?

Buntu has been robbed and had his things stolen. This year, how many times have you had things stolen? times

In the past year, how often did your carers...	weekly	monthly	at least once this year	never
Use a stick, belt or other hard item to hit you?				
Slap, punch or hit you so you were hurt?				
Said that you would be sent away or kicked out of the house?				
Said they would call ghosts or evil spirits, or harmful people?				
Insulted you by calling you dumb, lazy or other names?				

There are inappropriate ways to touch Buntu and Lindiwe. Has anyone ever touched you in a way that made you feel uncomfortable?

Has anyone ever made you do anything with your private parts or their private parts that you did not want to do?

Buntu was attacked and hit when he was out. Have you ever been hit or attacked outside?

Has anything happened which we have not mentioned which has upset you?

.....

.....

.....

.....

.....

.....

.....

Buntu saw someone in his neighbourhood being shot. Lindiwe saw someone being stabbed one evening.

Have you seen someone being shot?
Or stabbed?

how do you feel about...?

Many kids go through things that are very upsetting or frightening. We would like to know about them and how you felt about it. They might have happened recently or they might have happened a long time ago, but still upset you. They might have been in the list we asked you, or something else.

Can you tell us what was the most upsetting or frightening thing that has happened to you?

.....

.....

.....

.....

Now for each question, could you tick one box to show whether you have felt this way 'not at all', 'some of the time', 'most of the time' or 'all the time' in this past month:

	Not	Some	Most	All
 Do you get nightmares or bad dreams about what happened?	☐	☐	☐	☐
Do you get upset when you think about what happened? 	☐	☐	☐	☐
When something reminds you of what happened, do you get tense or upset?	☐	☐	☐	☐
 Do you go over and over what happened in your mind?	☐	☐	☐	☐
Do you think about (or see pictures in your head of) what happened even when you don't want to? 	☐	☐	☐	☐
Do you worry that it might happen again?	☐	☐	☐	☐
Do you try not to think about what happened?	☐	☐	☐	☐
Do you try to stay away from things that remind you of what happened?	☐	☐	☐	☐
Do you have trouble remembering important parts of what happened?	☐	☐	☐	☐
Do you act out things or repeat things like what happened?	☐	☐	☐	☐
 Do you feel like its happening all over again even when it's not?	☐	☐	☐	☐

	Not	Some	Most	All
Do you feel it's hard to have any feelings any more, like you feel numb?				
Do you make yourself very busy and do things so you won't think about what happened?				
Do you get physically upset when something reminds you of what happened - like getting sweaty, shaking, your heart pounding, getting short of breath, or stomach aches?				
 Do you have trouble falling asleep or staying asleep?				
Is it hard for you to pay attention - like listening to your teacher, or doing your work - because you can't concentrate well?				
Do you feel you need to stay 'on guard', like something could happen and you need to be ready?				
Do you get jumpy or startle easily?				
Do you get annoyed (grouchy) or irritable (kind of angry) real easy?				
 Do you get angry or upset at people for no reason?				
Do you get so angry at people you hit or hurt someone?				
Do you ever think you won't grow up and be what you want to be?				
 Do you feel it's hard to have fun doing things?				
Do you ever feel it's hard to feel happy?				
Do you feel alone even when other people are around?				
Do you feel bad or guilty - like what happened was your fault?				
Do you wet your pants or bed by accident?				
Do you feel like you are 'tuned out' or in a 'trance' so you can go away in your mind and not think?				

How do you usually get to your local clinic?

..... Walk Taxi Bus
..... Driven Train

How long does it take to get there? minutes

Health

We all get sick sometimes. Can you tell us whether you've had any of these in the past year?

Do you have any of these?

Asthma	Yes	No
How many asthma attacks in the last month?		
When you have an attack, do you have a puffer spray you can take?	Yes	No
Epilepsy	Yes	No
How many seizures in the last month?		
Are you taking your treatment every day?	Yes	No
Diabetes	Yes	No
How many times have you been sick in the past month? times		
Are you taking your injections or medicine every day?	Yes	No
<i>If yes to any of these...</i>		
When did you last go to hospital for this?		
Are you able to keep your clinic appointments:	always	sometimes
	never	

Does your family have a home-based carer who visits you?

..... yes no

How many times did they visit in the last month? times

On the last visit, did they spend time with you? yes no

How did they spend time with you? (XX)

..... time spent with emotional support
..... time showing me how to help the sick person
..... bringing protective gloves or other medical resources
..... time spent talking to me about my health
..... time spent helping me with my schoolwork
..... bringing food parcels or clothes or things to help me

Have you had these in the past month?

Cold or flu	Yes	No
General body pain (headaches, backaches etc)	Yes	No
Worms	Yes	No
Skin conditions (like a rash, or white itchy skin, or acne)	Yes	No

Have you had these in the past 6 months?

Pneumonia or bronchitis (really sick with cough, chest pain and yellow spit for at least 1 week)	Yes	No
Vomiting, diarrhoea or a runny tummy	Yes	No
Any injury or burn	Yes	No

Do you have these problems?

I have problems seeing properly	Yes	No
I have another kind of disability (what kind?)	Yes	No

Could you tell us how your health has been recently?

A cough where you spit up green or yellow stuff?	Yes	No
A bad cough lasting 3 weeks or longer	Yes	No
Pains in your chest	Yes	No
Tiredness and weakness	Yes	No
Have you lost weight without meaning to?	Yes	No
Do you have night sweats?	Yes	No
Are you coughing up blood?	Yes	No
Are you having a fever?	Yes	No
Has a nurse or doctor asked you to cough sputum into a little bottle test?	Yes - TB	Yes - not TB
Have you had TB in the past 2 years?	Yes	No
Were you given pills to take every day for TB?	Yes	No
If yes, how long did you take pills for? months / none at all		

For anything above (like TB, diabetes, flu...) could you tell us whether you visited these kinds of healthcare in the past two years?

	Yes	No, I didn't need to	I needed to but I couldn't
Chemist/pharmacy			
A public clinic			
A private doctor			
A traditional healer			
A healer at a church or medicines from the church			
A public hospital			
A private hospital			
Other (what kind?)			

If you needed to see someone but you couldn't, could you tell us why?

	Tick: (X)
I saw the person I needed to see	
I didn't have enough money for transport	
I was too busy helping out at home to go	
No one was available to go with me	
The health facility was too far away	
The queue or wait was too long	
The staff were unhelpful or lacked the skills to help me	
I could not decide what to do	
I didn't go for a religious reason	
I was afraid/embarrassed	
Another reason (what reason?)	
I don't know	

These are some tasks which kids do to help at home. How often have you done these things in the last month, and how long do they take?

	How many days in the week?	How long does this take you?
1. Wash other people's clothes		
2. Clean your home, yard, or other parts of the house		
3. Work in a food garden or tend animals		
4. Fetch water		
5. Collect firewood and/or make fires		
6. Do the grocery shopping		
7. Cook for other people		
8. Wash the dishes		
9. Do jobs for money (what kind?)		
10. Walk your siblings or other children to school/crèche		
11. Wash your siblings or other children		
12. Feed your siblings/other children		
13. Collect medicine from the clinic for a sick person		
14. Remind a sick person to take their medicine		
15. Give a sick person their medicine/treatment (what kind?)		
16. Take a sick person to the clinic		
17. Help a sick person to get dressed		
18. Massage a sick person/rub their body		
19. Stay with a sick person (to keep company or to watch them)		
20. Wash or bathe a sick person (feet, face, or other parts)		
21. Help sick person get around the house		
22. Help sick person to use the toilet		
23. Clean up after person has been sick (vomit, diarrhoea or other bodily fluids)		

Doing these things makes me feel: (XX)

☐ proud to help ☐ frustrated or irritated ☐ closer to the sick person ☐ sad

Helping out

Some kinds of caring mean we should be washing our hands or wearing protective gloves (made of a plasticky material).

Have you ever washed a sick person, cleaned or put bandages on a cut of a sick person, or washed the bedclothes or clothes of a sick person when they have vomited or had diarrhoea?		Yes	No
If yes, did you wear protective gloves?	Always	Sometimes	Never
If yes, did you wash your hands before and after?	Always	Sometimes	Never

My school is:

- we pay a school fee
- other kids pay school fees but I have an exemption
- a no-fees school
- I can't pay my school fees so I owe them to the school
- I don't go to school (*If you don't go to school, skip the rest of this page and go on to the next one!*)

school!

Sometimes we miss school a bit, sometimes a lot! And for all sorts of reasons. Remember that this is confidential. This year, how many times have you missed school for more than a week?

Why was that?

.....
.....
.....

Could you draw in this timetable for the past week what days you missed school and why?



Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Have you ever seen a counsellor at school?

..... yes no

Does your teacher understand your home situation?

..... no
..... a little bit
..... yes, a lot

Are you ever hungry at school?

..... never
..... sometimes
..... often
..... all the time

Do you have problems concentrating at school because you're worrying about something?

..... never
..... sometimes
..... often
..... all the time

Tick if you have any of these free at school:

- Free meal at school every day
(how many days in the past 7 days?
.....)
- Free transport (like a school bus)
- Free school uniform
- Free school textbooks

How do you usually get to school?

- walk taxi
- bus driven
- train bicycle

How long does it take you to get there?

..... minutes

Other kids and teenagers can be great. They can also be really mean to each other. Think about how things have been for you in the last 6 months. It would help if you answered all the questions even if you are not certain or if it seems silly!

	Not true for me	Somewhat true for me	Certainly true for me
I am usually on my own. I generally play alone or keep to myself			
I have one good friend or more			
Other people my age generally like me			
Other children or young people pick on me			
I get on better with adults than with people my age			
I try to be nice to other people			
I usually share with others			
I am helpful if someone is hurt, upset or feeling ill			
I am kind to younger children			
I often volunteer to help others			

OTHER TEENS AND ME



Now we want to know about the past year. During this year have other kids...

	Not at all	Once	2-3 times	4 or more times
Called me names or swore at me				
Tried to get me into trouble with my friends				
Took something without permission or stole things from me				
Made fun of me for some reason				
Made me uncomfortable by standing too close or touching me				
Punched, kicked or beat me up				
Hurt me physically in some way				
Tried to break or damaged something of mine				
Refused to talk to me or made other people not talk to me				

TEEN TALK CONFIDENTIAL PAGE

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential - they will be put in a sealed envelope. Please don't write your name on this sheet.

Sometimes we get upset, or just plain angry. Can you tell us how true these are for you in the past 6 months...?

	Not true	Somewhat true	Definitely true
I cut classes or skip school.			
I run away from home.			
I use alcohol or drugs for non-medical purposes.			
I don't feel guilty after doing something I shouldn't.			
I hang around with kids who get in trouble.			
I would rather be with older kids than with kids my own age.			
I graffiti or break windows.			
I steal at home.			
I steal things from places other than home.			
I swear or use dirty language.			
I lie or cheat.			
I get very angry and often lose my temper.			
I fight a lot. I can make other people do what I want.			
I usually do as I am told.			
I carry a knife on me for protection.			
I carry a gun on me for protection.			

During the past month, how often did you drink alcohol?

Never
 Every day
 Several times per week
 Once a week
 Once a month

In the past year, have you used any drug to make yourself feel high? Tick any you have: (XX)

..... not at all dagga mandrax
 glue petrol tik
 heroin benzene
 other (what?)

Have you been drunk in the past month?

Yes
 No

TEEN TALK CONFIDENTIAL PAGE

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential – they will be put in a sealed envelope. Please don't write your name on this sheet.

We all know that 'having sex' can mean a lot of things. Girls can sleep with boys, girls with girls, or boys with boys. Some of them have had anal sex. When we say 'had sex', we mean any one of these!

Have you ever had sex? Yes No

If your answer is 'No', do not fill in the rest of this page. Go on to the next page!

1 How old were you the first time you had sex? Write down the age:

2 How many people have you had sex with in the past year? Write down the number:

Of these people in the past year, write down how many of them were:
 your main boyfriend/girlfriend, or a husband/wife?
 someone who wasn't your main partner, but you had sex with quite regularly?
 a casual partner like a one-night stand?
 someone you paid to have sex with?

3

If you have had sex in the past year, how often did you use condoms?
 always
 more than half the time
 half the time
 less than half the time
 never

4

5 Has anyone that you've had sex with been more than 5 years older than you?
 Yes No

Have you ever had sex with someone when you didn't want to because they hurt you, or you were afraid that they were going to hurt you if you didn't?
 Yes No

8

6 Have you ever had sex when you were drunk?
 Yes No

7 Have you ever had sex when you were high on a drug like tik, dagga or anything else?
 Yes No

Have you ever heard of HIV/AIDS?
 Yes No

9

Quickly write down any things you think a person can do to avoid getting HIV, the virus that causes AIDS.

People have sex for lots of different reasons and for different benefits. Sometimes, people give presents to the person they are having sex with. Have you had any of the following presents given to you because you had sex with someone? Circle which ones:

10
 (XX)

Money Buying you drinks
 Clothes Cellphone airtime
 A place to stay Lifts in a car/taxi
 Better marks at school School fees
 Food Anything else

HIV can be spread when people have sex. What do you think your chances of getting HIV/AIDS are?
 no chance at all
 a little chance
 pretty much 50/50
 a very big chance
 I have been tested in the past 3 months and know my status
 I don't know what HIV/AIDS is

11

12 Have you ever been pregnant or made someone pregnant?
 Yes No

Do you have any children? Please write their ages:

13



Plants and animals

Some kids grow food to eat or have animals to take care of. Can you answer these quick questions about your home?

Do you or your family grow food to eat in any of these?

- a school garden,
- a community garden
- at home

List any vegetables or fruit that you grow in a garden, and any animals that your family owns!

.....

.....

.....

.....

.....

NOW



MY PLANS

MY FUTURE!

What job do you want when you are grown up?
What are your plans to get there?



MY JOB!

"The greatest glory in living lies not in never falling, but in rising every time we fall."

- Nelson Mandela

Caregiver consent form

Dear Parents/Guardians

We would like to invite your child to take part in research that is being run by a number of universities and by the South African government. The research will be asking about the well-being of children in South Africa. We will be talking to 6000 children in four different provinces and the research will take what children and their carers say to the South African Government and to other organisations working with children. The government will use this research to help their planning for children.

This research will be asking young people about their everyday lives, their feelings and their relationships. If you give permission, your child will fill in a questionnaire, with the help of an interviewer. This will take about an hour. Young people can choose whether they want to take part or not, and they can stop the interview at any time. Everything we are told will be treated as entirely confidential, unless children are at risk of serious harm, in which case we will try to help.

If you have any questions or worries about the research, please tell a member of our research team and they will be very happy to discuss or explain further to you.

Please fill in the slip below and let us know whether you give permission.

Thank you,

Lucie Cluver

Dr Lucie Cluver (Researcher), Cape Town Child Welfare



If you have any questions or complaints about this study, please contact Dr Lucie Cluver at Cape Town Child Welfare: 021 638 3127
Email: lucie.cluver@socres.ox.ac.uk

Privacy code:

Name of Participant	Child's grade
Can the child I care for take part in this study?	YES NO
Name of parent/guardian.....	Date



Follow-up questionnaire

TEEN TALK 2

TEEN TALK SOUTH AFRICA

Great to see you - thank you for talking to us again! Just like last time, whatever you say is confidential. This means we will not report your real name.

Real name:

Made-up name:

Questionnaire number: Boy/Girl

Place of interview:

School/org: Grade:

ID number:

Interviewer: Date:

Enumeration Area Number:

GPS latitude (S): S.....°.....'.....

GPS longitude (E): E.....°.....'.....

EMIS #:

Privacy code:

Would you mind if we contacted you again? Please write your address and telephone number so we can get back in touch:

Address:

.....

.....

Telephone:

This is not a test. There are no right or wrong answers! This research aims to help young people in South Africa. Thank you for taking the time to help.

YoungCarers
PROJECT SOUTH AFRICA

TEEN TALK 2 SOUTH AFRICA

Just like last time, please take time to read this sheet carefully and decide whether you do or don't want to take part. Ask the research team if there is anything that is not clear or if you have questions. Thank you for reading this.

What is this study about? This study is about young people and their feelings about their lives. The government wants to know more so they can plan how to help young people and families better.

Do I have to take part? Not at all. It is up to you to decide whether or not to take part. If you do not want to, this will not affect any help you may be getting from anyone. You will not get in any trouble if you do not want to take part.

If you decide to take part, you are still free to stop at any time. You don't have to give a reason. Again, this will not affect any help or support you are getting from anyone. We may come back in the future to see how you are doing. You can choose then whether you want to talk to us again!

What would I have to do? If you decide to take part, you will first sign a consent form (on the next page), and then spend about an hour talking together and doing activities with a researcher.

What if the questions upset me? You can stop at any point, and you do not have to give a reason. You can also contact the research team at any point after the group, and say that you want your answers about certain questions to be destroyed, which we will do straight away. If you want to talk to someone about anything that has come up from this, you can tell one of the researchers or contact the Young Carers Team at Cape Town Child Welfare (021 638 3127).

Why should I take part in this study? This may help us to know more about what can help young people in South Africa. What you tell us will help inform future government policy.

What if I have a complaint? If there is anything to do with this research which you are unhappy with, you can complain to Dr. Lucie Cluver at Oxford University (lucie.cluver@socres.ox.ac.uk).

Will what I say be kept confidential? Anything you tell us about yourself will be kept strictly confidential, and will not be told to anyone else. Any information about you would have your name and address changed so that you cannot be recognised from it.

But during this study, it may become clear that you are suffering from serious difficulties. If so, the interviewer will explain to you some possibilities for further help. If there is a safety issue, we may contact a welfare organisation for you. All this will be talked over with you first.

What will happen to the results of the research study? The results of this study will be used to help the government and others to make policies for young people and families in situations much like yours.

Who is organising and reviewing the research? The research is being organised by the University of Oxford in England, the University of Witwatersrand, the University of KwaZulu-Natal and the University of Cape Town. The research is also working with the Department of Social Development, the Department of Health and the Department of Basic Education in Pretoria. Ethics groups in both countries have approved the research. If you have any complaints about ethics in the Western Cape, please contact the UCT Health Sciences Research Ethics Committee (E52-23 Old Main Building, Groote Schuur Hospital, Observatory, 7925). If you have any complaints in Mpumalanga or in Gauteng, please contact the University of Witwatersrand Research Ethics Committee - telephone: (011) 717 7123/4.



Contact for further information: Dr Lucie Cluver, Cape Town Child Welfare, Lower Klipfontein Road, Gatesville, Athlone, South Africa 8000. Email: lucie.cluver@socres.ox.ac.uk

Thank you for reading this sheet. If you feel comfortable with everything, you can fill in the box:

Do I want to take part?

Tick:

1. I have read and understand the information sheet for this study and have had the chance to ask questions
2. I understand that I have chosen to take part and that I am free to stop at any time, without giving any reason. This will not change any support or help I am getting
3. I agree that any words I may say during the interview can be used, without giving my name, in the presentation of the research. I agree to take part in the study

☐
☐
☐

Sign:

.....
Name of participant

.....
Signature

.....
Name of researcher

.....
Date



social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA



health

Department:
Health
REPUBLIC OF SOUTH AFRICA



basic education

Department:
Basic Education
REPUBLIC OF SOUTH AFRICA



agriculture,
forestry & fisheries

Department:
Agriculture, Forestry and Fisheries
REPUBLIC OF SOUTH AFRICA



UNIVERSITY OF
OXFORD



HEARD



UNIVERSITY OF
KWAZULU-NATAL



UNIVERSITY OF CAPE TOWN



UNIVERSITY OF THE WITWATERSRAND
JOHANNESBURG



BROWN



E-S-R-C
ECONOMIC & SOCIAL
RESEARCH
COUNCIL



NRF



CLAUDE LEON
FOUNDATION



Cape Town
Child Welfare



THOLULWAZI
UZIVIKELA



Thembalitsha



EDUCATION

Could you give us the names, addresses and telephone numbers of 2 people (who you don't live with) who you think would know how to contact you in a few years time?

1.
.....
.....
.....
.....
.....
.....
.....
2.
.....
.....
.....
.....
.....
.....
.....

Last time, you filled in a Road of Life. We want to know what's changed in the last year.

Could you tell us...

What grade are you in now?

Are you in a different school to last year?

..... No Yes - name of new school:

Have you left school? No Yes - why?

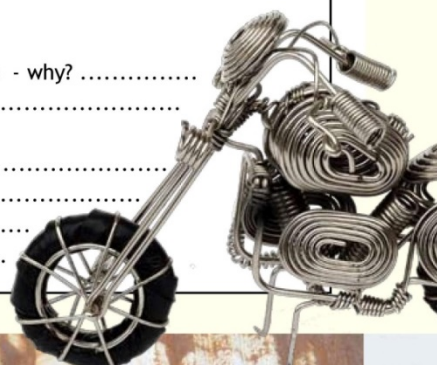
Have you repeated or failed a grade? No Yes - why?

Have you moved home? No Yes

Have you moved to another town or area? No Yes - why?

Has your main caregiver changed? No Yes - why?

CATCHING UP



Please circle the one which is most like your home:

1. house made of brick or concrete



2. hut made of traditional materials



3. shack on its own plot



4. living on the street

5. shack in a back yard



6. block of flats



7. children's home or shelter for kids



8. other (what kind?)

Where do you get your water from?

1: a tap in my house

2: a community tap that lots of people use (how long does it take you to get to it?)

3: a river or stream



MY HOUSE

4

PEOPLE I LIVE WITH

How many rooms are there in your home, like a bathroom kitchen and other rooms?
Draw them below.

1) Who sleeps in each room? 2) Write down their relationship to you, 3) whether they are a boy or girl and 4) how old they are! 5) Please circle anyone in the house who is sick.

6) Now, could you put a tick next to anyone in the home who has a job? Write down next to them whether it is a regular job (every day) a part-time job (some days each week) or a 'sometimes' job (like just over harvest, or on a building project).

5

7) If you don't live with a parent/s, could you say where they are?

Mom	Dad

Please tick the things which you can afford at home:

☐ 3 meals a day



☐ toiletries to be able to wash every day



☐ school fees



☐ school uniform

☐ school equipment



☐ visit to the doctor when you are ill, and all the medicines you need



☐ enough clothes to keep you warm and dry



☐ more than one pair of shoes



Do you have an ID book?
Yes No

Do you have a birth certificate?
..... Yes No

Is the household receiving any grants? (XX)

- no grants
- foster care grant
- child support grant
- pension
- disability grant
- care dependency grant

If you should be getting a grant but aren't, do you know the reason why?

- Didn't have the right documents (ID, birth certificate etc)
- Waiting for a social worker to do an assessment
- Can't afford transport to the grant office
- The grant office sent us away
- Another reason (tell us?)
- Not applicable

Plants and animals

Some kids grow food to eat or have animals to take care of. Can you answer these quick questions about your home?

Do you or your family grow food to eat in any of these?

- a school garden,
- a community garden
- at home

List any vegetables or fruit that you grow in a garden, and any animals that your family owns!

.....

.....

.....

.....

Sometimes kids don't have enough food in their home. How many days in the past 7 days did you not have enough food in your home?

How many days did you go to bed hungry?

Do you get the same amount of food as other kids in your home?
..... More The same Less



people looking after other people

If you do, please write their name here:
How old is this person?

Do you have a parent, guardian
or caregiver staying with you
and taking care of you at home?
..... yes no

Is this person your:

..... Brother Uncle Stepfather Neighbour/family friend
..... Grandma Biological father Sister Aunt
..... Foster mother Stepmother Grandpa Biological mother
..... No-one Social worker/careworker Foster father
..... Other (who?)

Has your caregiver talked to you
about who you will live with if they
aren't able to look after you any-
more?

..... Yes No

If they have, who will that person
be?

.....
.....

Has anyone close to you died? Could you tell us
who they were? And when? Do you know what
happened? (you can write, or draw them)

Some kids have parents who were ill for some time before they
died. Or their parent is unwell at the moment. It's difficult for kids
to handle sometimes. Could you say how much these things are
true for you?

Because someone in my family is sick or has died...

	Not at all	Sometimes	All the time
I've been teased			
I've been treated badly			
People have gossiped behind my back			
I worry about being rejected			
Parents who know don't want me around their kids			
I avoid making new friends			
I feel different and alone			
If people know, they avoid touching me			
If people know, they are afraid of me			
If people know, they think I am a bad person			

Did this upset you?

..... Not at all Somewhat Very much

This part of the questionnaire looks at sadness and other difficulties which many people experience at some point in their lives. For each group of 3 statements, pick out which best describes how you have felt in the last 2 weeks...

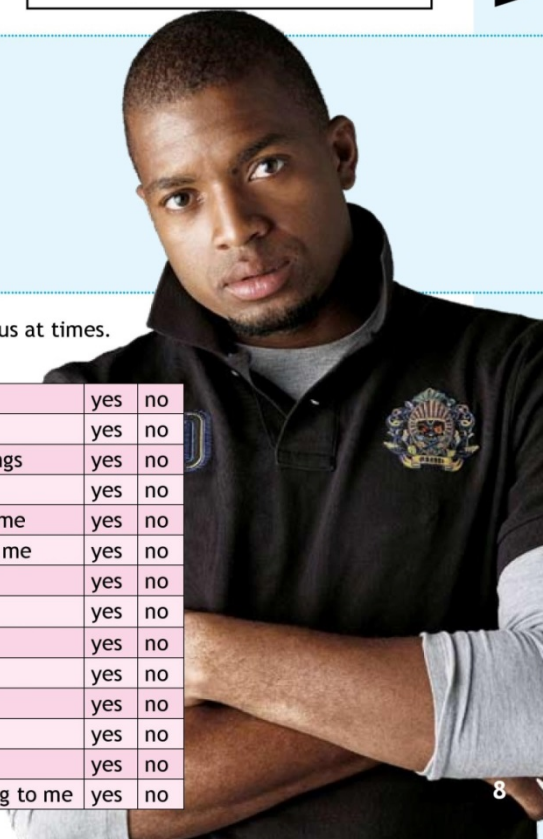
- 1 Nothing will ever work out for me
..... I am not sure if things will work out for me
..... Things will work out for me OK
- 2 I am sad once in a while
..... I am sad many times
..... I am sad all the time
- 3 I look OK
..... There are some bad things about my looks
..... I look ugly
- 4 I hate myself
..... I do not like myself
..... I like myself
- 5 I do not feel alone
..... I feel alone many times
..... I feel alone all the time
- 6 I do most things OK
..... I do many things wrong
..... I do everything wrong
- 7 I have plenty of friends
..... I have some friends but wish I had more
..... I don't have any friends
- 8 I feel like crying every day
..... I feel like crying many days
..... I feel like crying once in a while
- 9 Nobody really loves me
..... I am not sure if anybody loves me
..... I am sure that somebody loves me
- 10 Things bother me all the time
..... Things bother me many times
..... Things bother me once in a while

In the past month did you:

- Wish you were dead?
Want to hurt yourself?
Think about killing yourself?
Think of a way to kill yourself?
Try to kill yourself?

Many kids and teenagers feel nervous or anxious at times.
Please say which of these is true for you:

1. I worry a lot of the time	yes	no
2. I worry about what my carers will say to me	yes	no
3. I feel that others do not like the way I do things	yes	no
4. It is hard for me to get to sleep at night	yes	no
5. I worry about what other people think about me	yes	no
6. I feel alone even when there are people with me	yes	no
7. I worry about what is going to happen	yes	no
8. Other children are happier than I am	yes	no
9. I have bad dreams	yes	no
10. I wake up scared some of the time	yes	no
11. I worry when I go to bed at night	yes	no
12. I am nervous	yes	no
13. A lot of people are against me	yes	no
14. I often worry about something bad happening to me	yes	no



Please remove this page and seal in envelope for privacy. Please **DO NOT** write your name on this page.

Questionnaire no:

In the past year, how often did your caregivers or other adults...

	Weekly	Monthly	At least once this year	Never	Has happened to me but not in the last year	Caregiver	Other... Please state if a - Teacher - Relative - Neighbour - Other (who?)	If yes, where... Where did it happen? Please state if - Home - Community - School - Home of neighbour - Other (where?)
Use a stick, belt or other hard item to hit you								
Make you stand or kneel in an uncomfortable position for a long period of time								
Slap, punch, hit, pinch or pull your ear/hair so that you were hurt or had marks								
Single you out to do household chores all day instead of school or play								
Threaten to hurt you or give you bad grades								
Say they would call ghosts or evil spirits, or harmful people								
Tell you they wished they did not have to look after you or make you feel you are a burden								
Make you feel unwelcome in the home								
Say that you would be sent away or kicked out of the house								
Call you dumb, lazy, or other names								
Insult members of your family that have passed away								
Threaten to leave you and never come back								
Threaten to hurt or kill a person or an animal that you care about								
Withhold a meal to punish you								

DIFFICULT THINGS

Please remove this page and seal in envelope for privacy. Please DO NOT write your name on this page.

Questionnaire no:

There are inappropriate ways to touch children. How often in the past year has the following happened to you?	How often				Has happened to me but not in the last year	If yes, who.... Other person... - Boyfriend/girlfriend - Teacher - Relative - Neighbour - Other (who?)	If yes, where.... - Home - Community - School - Home of neighbour - Other (where?)
	Weekly	Monthly	At least once this year	Never			
Someone told you, you look sexy in a way that made you feel uncomfortable							
Someone touched or kissed you in a way that made you feel uncomfortable							
Someone touched your private parts or asked you to touch their private parts even though you did not want this to happen							
Someone forced you to have sex with them in any way when you did not want to							
Someone forced you to watch sexual things or pictures with nude images							

If this happened to someone you knew, where would you tell them to get help?
(all kids)

.....

.....

.....

.....

Have you asked for help before?

..... Yes No

Who did you ask?

.....

What actions were taken?

.....

.....

.....

.....

.....



10

DIFFICULT THINGS

SUPPORT

Please answer these questions about stuff that happens at home - just tick the best answer:

	Never	Almost never	Sometimes	Often	Always
Your carer says you have done something well					
Your carer threatens to punish you and then does not do it					
You go out without a set time to be home					
You talk your carer out of punishing you after you have done something wrong					
You stay out in the evening past the time you are supposed to be at home					
Your carer compliments you when you have done something well					
Your carer praises you for behaving well					
Your carer does not know who you are friends with					
Your carer lets you out of a punishment early					
Your carer tells you that they like it when you help out around the house					
Your carer gave you a small gift at the end of the year to show you they were proud of your school results					

How about these kinds of help?
And how reliable are they?

	Regular (at least once a month)	Sometimes	Never
A food parcel			
A meal at a soup kitchen			

Has your family had help from a traditional healer with sickness or death?

..... Yes (what kind of help?)
..... No

What kinds of support do you get from people in your life?

	This person is a person in my life		This person is helpful when I have a personal problem			This person is helpful when I need money and other things			I have fun with this person		
	yes	no	not at all	sort of	very	not at all	sort of	very	not at all	sort of	very
Your caregiver											
Your sisters or brothers											
A teacher, or the school principal											
A religious leader											
Your best friend											
Your group of close friends											
Other people (like other family here or far away) - tell us who:											



11

	A lot	Some	A little	None
How much comfort does my religion give me?				

Have you gone to see a religious leader when things have been difficult?
.....YesNo

If yes, who was this person?

..... minister imam traditional leader
..... member of the congregation other - who?.....

Did this person try to help you?YesNo

If yes, what did they do?.....

Fill this out only if someone is unwell in the home.

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential – they will be put in a sealed envelope. Please don't write your name on this sheet.

Who is the person who you help look after most?

How old are they?

How long have they been sick for?

In the past month, is this person's health

☐ Very good ☐ good ☐ moderate ☐ bad ☐ very bad

Has this person been happy in the past month?

☐ very happy ☐ happy ☐ ok ☐ sad ☐ very sad ☐ angry

How often in the past month has this person been unwell?

☐ never ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ all month

When people are unwell, they find it difficult to do everyday things. Could you think about what this person finds hard to do?

	Not at all difficult	A little difficult	Very difficult	Not able to do it
Carrying shopping				
Climbing into a taxi or bus				
Bending or kneeling				
Walking a kilometre				
Walking 100 metres				
Washing or dressing				
Getting out of bed				

Could you tell us what this person is sick with?

XX

- ☐ Have they lost weight and become very thin?
- ☐ Have they got diabetes?
- ☐ Have they had any of these things: very pale, or hair changing colour, or legs swelling up, or burning feelings in their feet, or has their skin been very dry?
- ☐ Do they have emotional problems?
- ☐ Have their eyes been yellow, and they've had a fever? Or itching?
- ☐ Have they had shingles or a rash on their skin?
- ☐ Have they got high blood pressure?
- ☐ Have they had sores on their body?
- ☐ Have they had ulcers or white patches in their mouth, or problems swallowing food?
- ☐ Do they drink alcohol too much?
- ☐ Do they have cancer? Where is the cancer?
- ☐ Have they had trouble breathing, or a cough for more than 2 days with fever?
- ☐ Have they had TB in the last five years?
- ☐ Do they have arthritis?
- ☐ Have they been bewitched?
- ☐ Have they had diarrhoea or a runny tummy for more than 2 days?
- ☐ Do they have HIV?
- ☐ Have they had anything else we haven't asked about? (What do they have?)

CONFIDENTIAL SICKNESS REPORT SHEET

12

CONFIDENTIAL PARENT REPORT SHEET

Fill this out only if a parent has died.

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential - they will be put in a sealed envelope. Please don't write your name on this sheet.

How was this person related to you?

How old was this person when they died?

Do you know what happened?

- ☐ road accident
- ☐ illness - do you know what?
- ☐ attacked
- ☐ something else (Could you tell us?

How long were they sick for?

Can you get their death certificate when you need it for grants? ☐ Yes ☐ No

Could we ask you about some of the symptoms of sickness your parent had before they died?

- ☐ Did they lose weight and become very thin? (XX)
- ☐ Did they have diabetes?
- ☐ Did they have any of these things: very pale, or hair changing colour, or legs swelling up, or burning feelings in their feet, or was their skin very dry?
- ☐ Did they have emotional problems?
- ☐ Were their eyes yellow, and they had a fever? Or itching?
- ☐ Did they have shingles or a rash on their skin?
- ☐ Did they have high blood pressure?
- ☐ Did they have sores on their body?
- ☐ Did they have ulcers or white patches in their mouth, or problems swallowing food?
- ☐ Did they drink alcohol too much?
- ☐ Did they have cancer? Where was the cancer?
- ☐ Did they have trouble breathing, or a cough for more than 2 days with fever?
- ☐ Did they have TB in the last five years?
- ☐ Did they have arthritis?
- ☐ Were they bewitched?
- ☐ Did they have diarrhoea or a runny tummy for more than 2 days?
- ☐ Did they have HIV?
- ☐ Did they have anything else we haven't asked about? (What did they have?)

Would you like to draw or write something for your parent?

Questionnaire no:

Thank you for helping us with this. These questions are totally confidential – they will be put in a sealed envelope. Please don't write your name on this sheet.

Sometimes we get upset, or just plain angry. Can you tell us how true these are for you in the past 6 months...?

	Not true	Somewhat true	Definitely true
I cut classes or skip school.			
I run away from home.			
I use alcohol or drugs for non-medical purposes.			
I don't feel guilty after doing something I shouldn't.			
I hang around with kids who get in trouble.			
I would rather be with older kids than with kids my own age.			
I graffiti or break windows.			
I steal at home.			
I steal things from places other than home.			
I swear or use dirty language.			
I lie or cheat.			
I get very angry and often lose my temper.			
I fight a lot. I can make other people do what I want.			
I usually do as I am told.			
I carry a knife on me for protection.			
I carry a gun on me for protection.			

During the past month, how often did you drink alcohol?

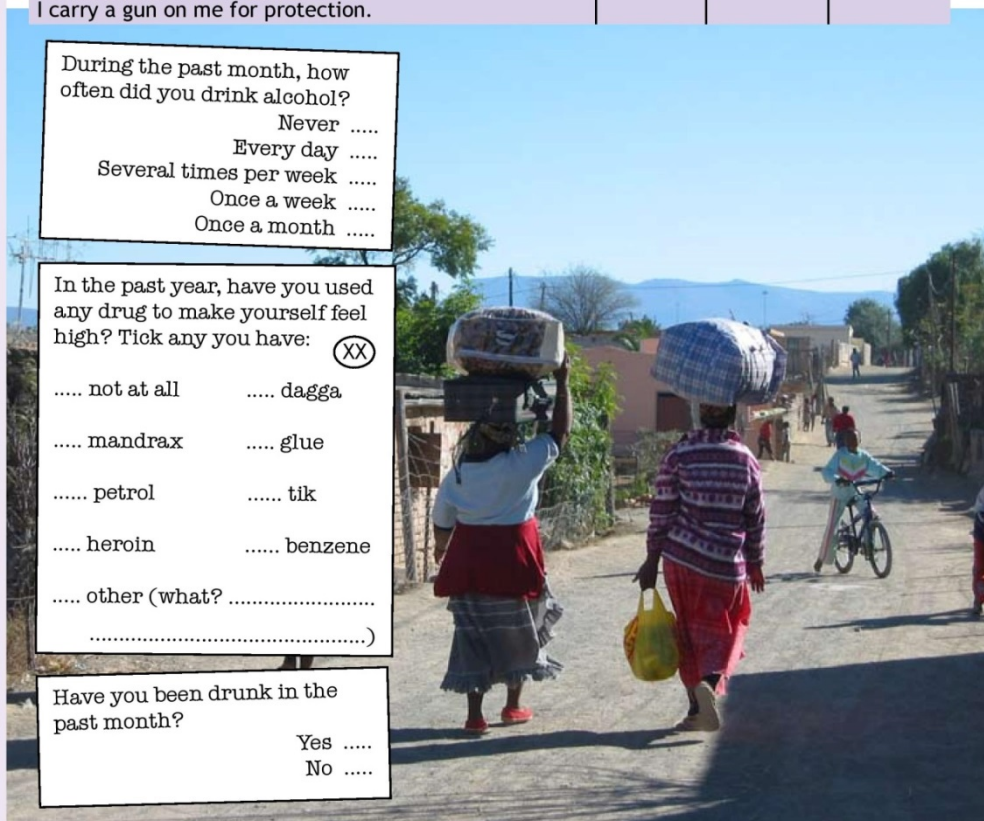
Never
Every day
Several times per week
Once a week
Once a month

In the past year, have you used any drug to make yourself feel high? Tick any you have: (XX)

..... not at all dagga
..... mandrax glue
..... petrol tik
..... heroin benzene
..... other (what?)
.....

Have you been drunk in the past month?

Yes
No



We all know that 'having sex' can mean a lot of things. Girls can sleep with boys, girls with girls, or boys with boys. Some of them have had anal sex. When we say 'had sex', we mean any one of these!

Thank you for helping us with this. These questions are totally confidential - they will be put in a sealed envelope. Please don't write your name on this sheet.

Questionnaire no:

1 How old were you the first time you had sex? Age / I have not had sex

Sometimes people have sex from choice and sometimes they are forced.
Have you ever had sex?YesNo
Or been forced?YesNo

If you have not ever had sex, go straight to Q.9 and Q.11.

2 How many people have you had sex with in the past year? Write down the number:

Of these people in the past year, write down how many of them were:
..... your main boyfriend/girlfriend, or a husband/wife?
..... someone who wasn't your main partner, but you had sex with quite regularly?
..... a casual partner like a one-night stand?
..... someone you paid to have sex with?
..... someone who forced you to have sex

If you have had sex in the past year, how often did you use condoms?
..... always
..... more than half the time
..... half the time
..... less than half the time
..... never

5 Has anyone that you've had sex with been more than 5 years older than you?
..... Yes No

6 Have you ever had sex when you were drunk?
..... Yes No

7 Have you ever had sex when you were high on a drug like tik, dagga or anything else?
..... Yes No

8 Have you ever had sex with someone when you didn't want to because they hurt you, or you were afraid that they were going to hurt you if you didn't?
..... Yes No

9 Have you ever heard of HIV/AIDS?
..... Yes No

Quickly write down any things you think a person can do to avoid getting HIV, the virus that causes AIDS.

10 People have sex for lots of different reasons and for different benefits. Sometimes, people give presents to the person they are having sex with. Have you had any of the following presents given to you because you had sex with someone? Circle which ones: (XX)

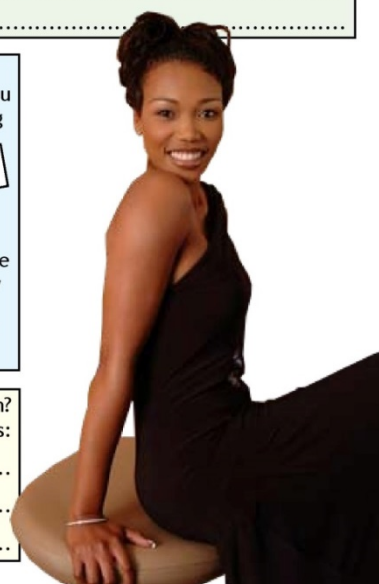
Money Buying you drinks
Clothes Cellphone airtime
A place to stay Lifts in a car/taxi
Better marks at school School fees
Food Anything else

HIV can be spread when people have sex. What do you think your chances of getting HIV/AIDS are?
..... no chance at all
..... a little chance
..... pretty much 50/50
..... a very big chance
..... I have been tested in the past 3 months and know my status
..... I don't know what HIV/AIDS is

13 Do you have any children? Please write their ages:
.....
.....
.....

12 Have you ever been pregnant or made someone pregnant?
..... Yes No

15





Here are Buntu and Lindiwe, telling us some things which many kids in South Africa have experienced. Could you tell us whether these things have happened to you also?

1

Buntu's family have lots of arguments. Sometimes adults shout at each other and sometimes there is fighting. This last week, how many days were there arguments with adults shouting in your home?

What were these arguments mainly about?

How many days were there arguments with adults hitting each other in your home?

2

Buntu has been robbed and had his things stolen. This year, how many times have you had things stolen? times

3

Buntu was attacked and hit when he was out. Have you ever been hit or attacked outside?

4

Buntu saw someone in his neighbourhood being shot. Lindiwe saw someone being stabbed one evening.

Have you seen someone being shot?
Or stabbed?

5

Has anything happened which we have not mentioned which has upset you?

.....
.....
.....
.....
.....
.....

HOW DO YOU FEEL ABOUT...?

Many kids go through things that are very upsetting or frightening. We would like to know about them and how you felt about it. They might have happened recently or they might have happened a long time ago, but still upset you. They might have been in the list we asked you, or something else.

Can you tell us what was the most upsetting or frightening thing that has happened to you?

.....

.....

.....

.....

.....

Now for each question, could you tick one box to show whether you have felt this way 'not at all', 'some of the time', 'most of the time' or 'all the time' in this past month:

	Not	Some	Most	All
 Do you get nightmares or bad dreams about what happened?	☐	☐	☐	☐
Do you get upset when you think about what happened? 	☐	☐	☐	☐
When something reminds you of what happened, do you get tense or upset?	☐	☐	☐	☐
 Do you go over and over what happened in your mind?	☐	☐	☐	☐
Do you think about (or see pictures in your head of) what happened even when you don't want to? 	☐	☐	☐	☐
Do you worry that it might happen again?	☐	☐	☐	☐
Do you try not to think about what happened?	☐	☐	☐	☐
Do you try to stay away from things that remind you of what happened?	☐	☐	☐	☐
Do you have trouble remembering important parts of what happened?	☐	☐	☐	☐
Do you act out things or repeat things like what happened?	☐	☐	☐	☐
 Do you feel like its happening all over again even when it's not?	☐	☐	☐	☐

HOW DO YOU FEEL ABOUT...?

	Not	Some	Most	All
Do you feel it's hard to have any feelings any more, like you feel numb?				
Do you make yourself very busy and do things so you won't think about what happened?				
Do you get physically upset when something reminds you of what happened - like getting sweaty, shaking, your heart pounding, getting short of breath, or stomach aches?				
 Do you have trouble falling asleep or staying asleep?				
Is it hard for you to pay attention - like listening to your teacher, or doing your work - because you can't concentrate well?				
Do you feel you need to stay 'on guard', like something could happen and you need to be ready?				
Do you get jumpy or startle easily?				
Do you get annoyed (grouchy) or irritable (kind of angry) real easy?				
 Do you get angry or upset at people for no reason?				
Do you get so angry at people you hit or hurt someone?				
Do you ever think you won't grow up and be what you want to be?				
 Do you feel it's hard to have fun doing things?				
Do you ever feel it's hard to feel happy?				
Do you feel alone even when other people are around?				
Do you feel bad or guilty - like what happened was your fault?				
Do you wet your pants or bed by accident?				
Do you feel like you are 'tuned out' or in a 'trance' so you can go away in your mind and not think?				

18

We all get sick sometimes. Can you tell us whether you've had any of these in the past year?

How do you usually get to your local clinic?
..... Walk Taxi Bus
..... Driven Train

How long does it take to get there? minutes

Do you have any of these?

Asthma	Yes	No
How many asthma attacks in the last month?		
When you have an attack, do you have a puffer spray you can take?	Yes	No
Epilepsy	Yes	No
How many seizures in the last month?		
Are you taking your treatment every day?	Yes	No
Diabetes	Yes	No
How many times have you been sick in the past month? times		
Are you taking your injections or medicine every day?	Yes	No
<i>If yes to any of these...</i>		
When did you last go to hospital for this?		
Are you able to keep your clinic appointments:	always	sometimes never

Does your family have a home-based carer who visits you?
..... yes no

How many times did they visit in the last month? times

On the last visit, did they spend time with you? yes no

(XX)

How did they spend time with you?
..... time spent with emotional support
..... time showing me how to help the sick person
..... bringing protective gloves or other medical resources
..... time spent talking to me about my health
..... time spent helping me with my schoolwork
..... bringing food parcels or clothes or things to help me

Have you had these in the past month?

Cold or flu	Yes	No
General body pain (headaches, backaches etc)	Yes	No
Worms	Yes	No
Skin conditions (like a rash, or white itchy skin, or acne)	Yes	No

Have you had these in the past 6 months?

Pneumonia or bronchitis (really sick with cough, chest pain and yellow spit for at least 1 week)	Yes	No
Vomiting, diarrhoea or a runny tummy	Yes	No
Any injury or burn	Yes	No

Do you have these problems?

I have problems seeing properly	Yes	No
I have another kind of disability (what kind?	Yes	No

Could you tell us how your health has been recently?

A cough where you spit up green or yellow stuff?	Yes	No
A bad cough lasting 3 weeks or longer	Yes	No
Pains in your chest	Yes	No
Tiredness and weakness	Yes	No
Have you lost weight without meaning to?	Yes	No
Do you have night sweats?	Yes	No
Are you coughing up blood?	Yes	No
Are you having a fever?	Yes	No
Has a nurse or doctor asked you to cough sputum into a little bottle test?	Yes - TB	Yes - not TB
Have you had TB in the past 2 years?	Yes	No
Were you given pills to take every day for TB?	Yes	No
If yes, how long did you take pills for? months / none at all		

For anything above (like TB, diabetes, flu...) could you tell us whether you visited these kinds of healthcare in the past two years?

	Yes	No, I didn't need to	I needed to but I couldn't
Chemist/pharmacy			
A public clinic			
A private doctor			
A traditional healer			
A healer at a church or medicines from the church			
A public hospital			
A private hospital			
Other (what kind?)			

If you needed to see someone but you couldn't, could you tell us why?

	Tick: (XX)
I saw the person I needed to see	
I didn't have enough money for transport	
I was too busy helping out at home to go	
No one was available to go with me	
The health facility was too far away	
The queue or wait was too long	
The staff were unhelpful or lacked the skills to help me	
I could not decide what to do	
I didn't go for a religious reason	
I was afraid/embarrassed	
Another reason (what reason?)	
I don't know	

HELPING OUT

These are some tasks which kids do to help at home. How often have you done these things in the last month, and how long do they take?

	How many days in the week?	How long does this take you?
1. Wash other people's clothes		
2. Clean your home, yard, or other parts of the house		
3. Work in a food garden or tend animals		
4. Fetch water		
5. Collect firewood and/or make fires		
6. Do the grocery shopping		
7. Cook for other people		
8. Wash the dishes		
9. Do jobs for money (what kind?)		
10. Walk your siblings or other children to school/crèche		
11. Wash your siblings or other children		
12. Feed your siblings/other children		
13. Collect medicine from the clinic for a sick person		
14. Remind a sick person to take their medicine		
15. Give a sick person their medicine/treatment (what kind?)		
16. Take a sick person to the clinic		
17. Help a sick person to get dressed		
18. Massage a sick person/rub their body		
19. Stay with a sick person (to keep company or to watch them)		
20. Wash or bathe a sick person (feet, face, or other parts)		
21. Help sick person get around the house		
22. Help sick person to use the toilet		
23. Clean up after person has been sick (vomit, diarrhoea or other bodily fluids)		

Doing these things makes me feel: (XX)

☐ proud to help ☐ frustrated or irritated ☐ closer to the sick person ☐ sad

Some kinds of caring mean we should be washing our hands or wearing protective gloves (made of a plasticky material).

Have you ever washed a sick person, cleaned or put bandages on a cut of a sick person, or washed the bedclothes or clothes of a sick person when they have vomited or had diarrhoea?	Yes	No
If yes, did you wear protective gloves?	Always	Sometimes
If yes, did you wash your hands before and after?	Always	Sometimes

Do you know what to do if you don't have gloves?

.....No Yes - what?.....

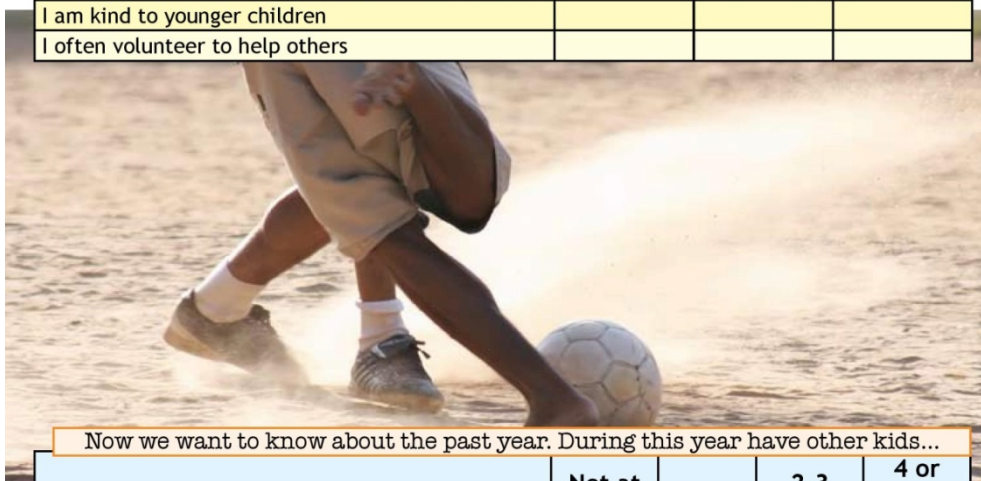
Do you know how to wash soiled clothes or bedclothes safely?

.....No Yes - how?.....

If you are standing close to someone who is coughing, what can you do to protect yourself from TB?Don't know / What?.....

Other kids and teenagers can be great. They can also be really mean to each other. Think about how things have been for you in the last 6 months. It would help if you answered all the questions even if you are not certain or if it seems silly!

	Not true for me	Somewhat true for me	Certainly true for me
I am usually on my own. I generally play alone or keep to myself			
I have one good friend or more			
Other people my age generally like me			
Other children or young people pick on me			
I get on better with adults than with people my age			
I try to be nice to other people			
I usually share with others			
I am helpful if someone is hurt, upset or feeling ill			
I am kind to younger children			
I often volunteer to help others			



Now we want to know about the past year. During this year have other kids...

	Not at all	Once	2-3 times	4 or more times
Called me names or swore at me				
Tried to get me into trouble with my friends				
Took something without permission or stole things from me				
Made fun of me for some reason				
Made me uncomfortable by standing too close or touching me				
Punched, kicked or beat me up				
Hurt me physically in some way				
Tried to break or damaged something of mine				
Refused to talk to me or made other people not talk to me				
Did this happen mainly...?	In school	Outside school	Both	

SCHOOL

My school is:

- we pay a school fee
- other kids pay school fees but I have an exemption
- a no-fees school
- I can't pay my school fees so I owe them to the school
- I don't go to school (*If you don't go to school, skip the rest of this page and go on to the next one!*)

Sometimes we miss school a bit, sometimes a lot! And for all sorts of reasons. Remember that this is confidential. This year, how many times have you missed school for more than a week?

Why was that?

.....

.....

.....

.....

Could you draw in this timetable for the past week what days you missed school and why?



Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Tick if you have any of these free at school:

- Free meal at school every day
(how many days in the past 7 days?
.....)
- Free transport (like a school bus)
- Free school uniform
- Free school textbooks

How do you usually get to school?

- walk taxi
- bus driven
- train bicycle

How long does it take you to get there?

..... minutes

Have you ever seen a counsellor at school?

..... yes no

Does your teacher understand your home situation?

..... no
..... a little bit
..... yes, a lot

Are you ever hungry at school?

..... never
..... sometimes
..... often
..... all the time

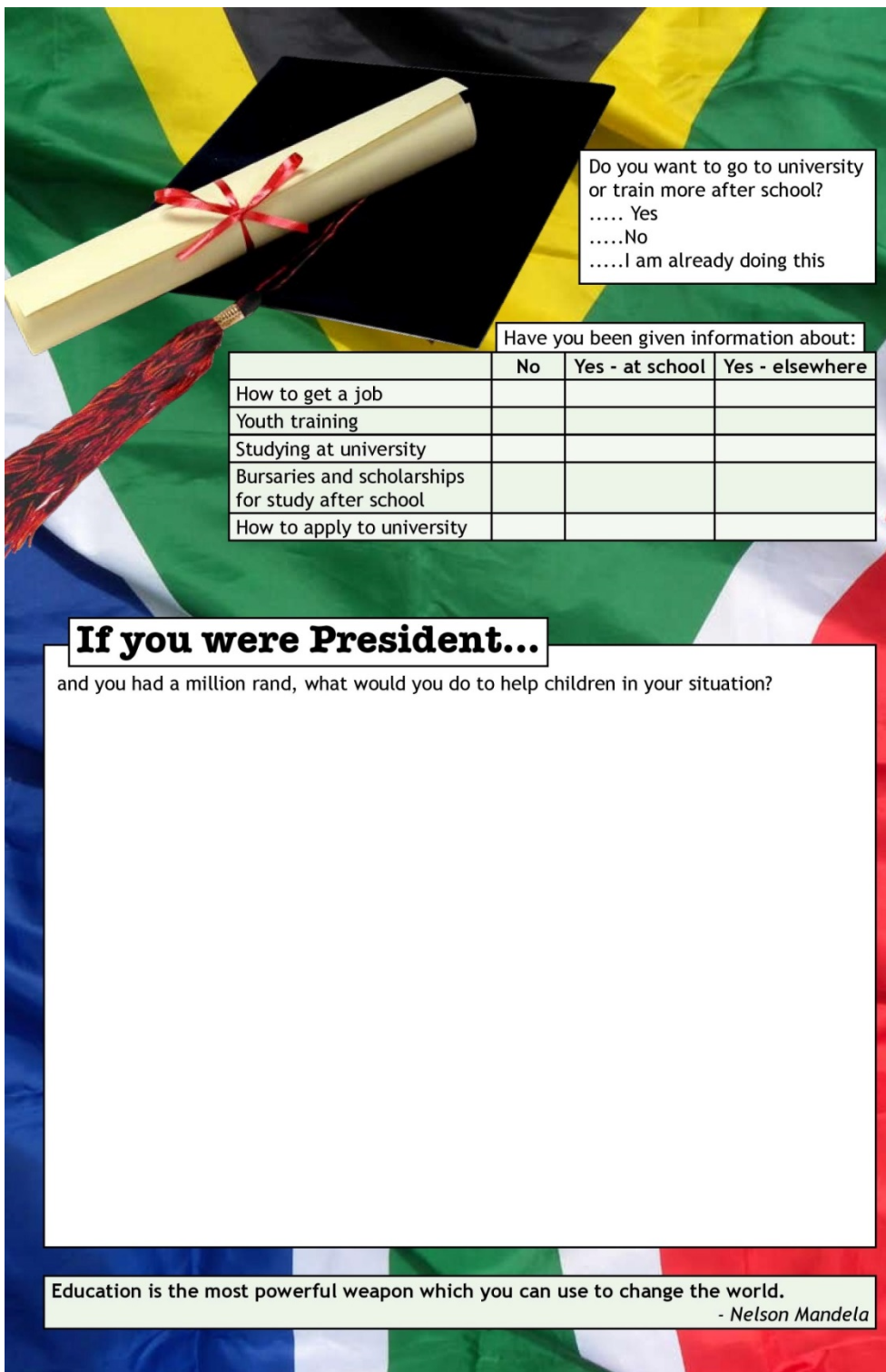
Do you have problems concentrating at school because you're worrying about something?

..... never
..... sometimes
..... often
..... all the time

Did your school have an HIV testing campaign? Yes No
Have you been tested? Yes (at school) Yes (elsewhere) No
If yes, which year were you tested?

We will give you now a blank sheet of paper and a card with some letters and information on it. If you feel you can confidentially tell us your status, please don't show it to us. Just write one of those letters on the paper.

Once you have written it down, fold it up and seal it, and put it in the envelope which does not have your name on it. We keep this envelope apart from the questionnaire, to make sure it is completely confidential.



Do you want to go to university or train more after school?
 Yes
No
I am already doing this

Have you been given information about:	No	Yes - at school	Yes - elsewhere
How to get a job			
Youth training			
Studying at university			
Bursaries and scholarships for study after school			
How to apply to university			

If you were President...

and you had a million rand, what would you do to help children in your situation?

Education is the most powerful weapon which you can use to change the world.
 - Nelson Mandela

Dear Parents/Guardians

Last year, your child took part in research that is being run by a number of universities and by the South African Government. We would like to invite your child to speak to us again a year later!

This research will be asking young people about their everyday lives, their feelings and their relationships. If you give permission, your child will fill in a questionnaire, with the help of an interviewer. This will take about an hour. Young people can choose whether they want to take part or not, and they can stop the interview at any time. Everything we are told will be treated as entirely confidential, unless children are at risk of serious harm, in which case we will try to help.

If you have any questions or worries about the research, please tell a member of our research team and they will be very happy to discuss or explain further to you.

Please fill in the slip below and let us know whether you give permission.

Thank you,

Lucie Cluver

Dr Lucie Cluver (Researcher), Cape Town Child Welfare

Privacy code:

If you have any questions or complaints about this study, please contact Dr Lucie Cluver at Cape Town Child Welfare: 021 638 3127
Email: lucie.cluver@socres.ox.ac.uk



Name of Participant

.....

Child's grade

Can the child I care for take part in this study?

YES NO

Name of parent/guardian

.....

Date

Appendix 9 Health and safety procedure

Health and safety procedure

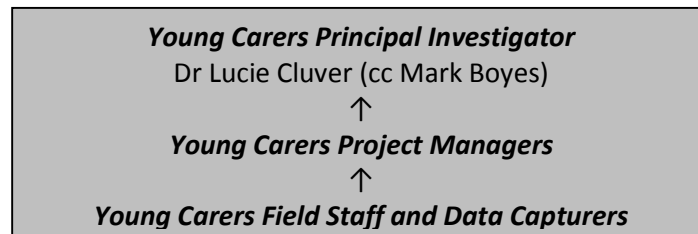


Young Carers South Africa – Safety Document

Overview:

This document aims to outline a general procedure that will be implemented to ensure the safety of all *Young Carers South Africa* staff. All staff should read this document and sign the declaration included. The structure for the reporting and documenting of any safety issues that might arise is outlined in the diagram below (contact details for the Principal Investigator and all *Young Carers* Project Managers are included at the end of this document). Appended to this document are also procedures put in place regarding personal safety, driving safety, fire and floods (and other natural disasters), as well as climate safety.

Hierarchy for the reporting and documenting of any safety concerns



Procedure:

1. Any staff safety concerns should be raised with Project Managers immediately. Project Managers will make a decision about whether to deal with this immediately, to discuss with the Principal Investigator, or to discuss in the weekly staff meeting at each provincial site
2. Project Managers and their team should determine whether the safety concern is likely to be a local issue, or whether this issue might impact other sites. If it is deemed that the concern may impact other sites the Principal Investigator and all other Project Managers should be informed immediately. Project Managers and staff at all sites should discuss the issue and any possible safety procedures that could be implemented to address it
3. If the concern is deemed to be relevant only to the local site, the Project Manager and staff should discuss the issue and any possible safety procedures that could be implemented to address the issue. The Project Manager should also contact the Project Managers of the other sites to determine whether the concern has been a problem in other provinces and, if so, what procedures were put in place to address it
4. If a safety procedure is decided upon, the initial concern and the proposed procedure should be documented (using a copy of the attached Safety Documentation Form). This form should be sent to the Principal Investigator (cc Mark Boyes). If the Principal Investigator has any suggestions, recommendations, or concerns these will be communicated directly to Project Managers
If a safety procedure cannot be decided upon the Principal Investigator should be informed and a conference call will be arranged so that the issue can be discussed between the Principal Investigator and all Project Managers
5. Once the safety procedure has been approved by the Principal Investigator the Safety Documentation Form should be appended to the office copy of the safety protocol (this document), this way a record of all safety concerns and staff responses is maintained. The other Project Managers should be emailed a copy of the form to append to their office copy of

the safety protocol, this way if the same issue arises at another site the approved response is immediately available

“I declare that I have read and understood this document. I am aware of the procedure that has been put in place to ensure the safety of *Young Carers South Africa* staff”

Name: _____
Site: _____
Signed: _____
Date: _____

Emergency contact: _____

Young Carers South Africa – Safety Procedures

Many of these safety procedures involve common-sense and are relevant across all safety domains

Personal Safety:

- Staff should carry a well-charged cell phone at all times in case of accident or emergency
- Where there is an immediate emergency and PMs are not on field or easily contactable, staff (eg RAs) should inform their field coordinators, who will inform the PMs
- Always inform another member of the *Young Carers* team about your destination and estimated time of return
- If requested, all *Young Carers* staff will be provided with a personal safety alarm
- Staff should carry ID cards and safety alarm where they are easily accessible (e.g. around neck)
- Staff should know the closest location to the local authorities to seek refuge if danger arises
- If possible, never leave a team member behind. It is best to intervene as a team
- If interviewing in a community in which you feel unsafe:
 - Inform your Project Manager
 - Form ‘Interviewer Groups’ (and include a male field worker if possible)
 - If necessary a CPF escort can be arranged
- If needed, staff should discuss emergency sms code for help with team members or PM
- Staff should work in teams of two (preferably with a male RA on each team) and within viewing distance of each other
- Staff should be carrying maps of the areas in which they work to facilitate orientation and giving directions

Dealing with Participants:

- Violent Participants:
 - Staff should **not** solve the matter independently
 - Staff should **not** respond violently (*so as not to promote escalating emotions*)
 - Do not confront a mob
 - Walk away and ignore the accusations

-
- Inform PM as soon as possible
 - If violent accusations result in physical harm, PMs should open an assault case at the police station
 - Unhappy Participants:
 - RAs should be aware of escalating emotions
 - When possible, re-address the objectives of the study, privacy guidelines for disclosure, and remind the participants that authorities in the areas are aware of the project study
 - If participant is not satisfied with the explanation, offer to make appointment with the project manager
 - Appease the unhappy participant by ensuring that their concerns will be heard and handled
 - Contact and inform project manager of the encounter

Driving Safety:

- Extreme caution should be used at all times when driving and all rules of the road should be obeyed
- In rural areas there may be a significant number of cattle on the road and drivers should be wary of this
- If requested, any person who will be driving a *Young Carers* project car will be provided with defensive driving training
- Using a mobile phone while driving (texting or calling) is a criminal offence in South Africa
- Staff should carry a well-charged cell phone at all times in case of accident or emergency
- Always get enough rest before you drive the car to avoid falling asleep behind the wheel
- When using the car for work purposes, another member of the *Young Carers* team should always be informed about your destination and estimated time of return
- Valuables should never be left in the car
- Your personal safety is more important than the car!

Wildlife:

- *Young Carers* team members should treat homes with dogs with caution
- Do NOT approach wildlife. Do not attempt to feed baboons!
- In rural areas you may encounter snakes. Snakes are most likely to bite when they feel threatened, are startled, are provoked, or have no means of escape when cornered. Encountering a snake is always considered dangerous and it is recommended that you leave the vicinity
- If requested, one member of each field work team will be provided with First Aid training
- Staff should carry a well-charged cell phone at all times in case of accident or emergency
- Stay clear off all areas where lions, cheetahs and leopards have been spotted

Climate:

- Heat: fieldworkers will be provided with sun screen, water bottles, and hats during the summer months
- Rain: fieldworkers will be provided with umbrellas and/or rain jackets

Fire, Floods, and Natural Disasters

- In any case of environmental hazard, consider your own safety and that of your team first
- The Project Manager and Principal Investigator will make a decision, in consultation with the fieldwork team, about how best to deal with these

Medical Conditions of staff members

- All staff with chronic medical conditions such as epilepsy or diabetes are requested to wear medical alert bracelets
- All staff are responsible to carry their medication with them at all times and show their team members where it is kept and how to administer it in an emergency

Taxi wars, riots, political violence

In the event of taxi wars, riots, or political violence discuss any safety issues with Project Managers, but in any case where there is risk to staff, fieldwork will suspend or move to another area

Miscellaneous:

In various sites fieldworkers have been accused of being Satanists

- This is being addressed through: addressing concerns that have lead to negative impressions of the project (e.g. that we're taking away legitimate/fraudulent grants), praying with the people who have accused fieldworkers of Satanism, working with local religious leaders to prevent any confusion about our affiliation
- All staff members are requested to register a telephone number of a relative or friend which can be contacted in case the member of staff is involved in an accident at work. Emergency numbers are to be kept on box.net so they are easily accessible for all members of the project.

For Project Managers

- PM's should make sure all field staff have a copy of documented safety procedures amongst field protocols and ask staff to sign for confirmation of having read and accepted adherence to them. Staff should also be encouraged to provide suggestions or highlight guidelines that are not working at team meetings.
- If re-addressing the objectives of the study has not always worked to calm down violent participants:
 - Inform the Indunas and ward councillors about the encounter and request another community meeting (with Indunas and local authorities -Community Development Forum staff, CDFs present)
 - Address some of the issues encountered and explicitly and patiently explain the **reason** for each questions (i.e. Who lives in my home) if necessary
 - Prior assessments of communities is crucial (get information on safety, crimes, witchcraft, etc.), and know the village and culture
 - Monitor your RAs, violent encounters can be traumatic. Offer psychological counselling (with local psychologists in hospitals) or debrief team members
 - If necessary, give RAs crisis prevention training or safety training.

Safety Concern – Documentation and Response Form

Date concern raised: _____

1) Safety Concern:

2) Proposed Response:

Response approved by PI: Yes/No
Site: KZN/WC/MP
Signed by Project Manager: _____
Date Approved: _____

Young Carers South Africa – Contact Details

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HIV/AIDS project policy



Young Carers South Africa HIV/AIDS Policy

Young Carers South Africa recognises that HIV/AIDS may threaten the wellbeing of our employees. In an effort to deal with the issue proactively, we are committed to assisting any of our employees infected with or affected by HIV/AIDS.

Our stance on HIV/AIDS is as follows:

- *Young Carers South Africa* **will not** carry out direct or indirect pre-employment screening for HIV/AIDS as a pre-requisite for employment
- *Young Carers South Africa* encourages all staff members to find out their HIV status and make use of appropriate support services
- *Young Carers South Africa* will do our best to provide information regarding local services to any HIV positive staff who request information or help
- All information regarding HIV status provided to Project Managers will be kept strictly confidential. It is up to individuals to inform other staff members about their HIV status, **if they choose to do so**
- *Young Carers South Africa* will endeavour to educate all staff members about HIV/AIDS prevention, transmission and treatment
- HIV infection, in itself, does not constitute lack of fitness to work, so a staff member cannot and will not be dismissed simply because he or she is HIV-positive
- If an employee is unable to work because of an AIDS-related illness, reasonable alternative working arrangements will be made wherever possible
- HIV/AIDS will be treated like any other medical condition when it comes to the granting of ill leave
- *Young Carers South Africa* will do our best to protect any member of staff against stigmatisation and discrimination in the workplace. Any staff members found to be stigmatising or discriminating against HIV positive staff will face disciplinary action
- Disciplinary action will be taken against any member of staff who is found to have deliberately disclosed the HIV/AIDS status of another staff member to a third party

