CHILD SEXUAL ABUSE AND HIV: 
STUDY OF LINKS IN SOUTH AFRICA & NAMIBIA

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REPORT FOR 
SAVE THE CHILDREN (UK) and (SWEDEN)
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Dedication

To the memory of Nomathemba Tshepo Twala
December 8, 1997 to October 24, 2002

and

to all girls and boys from all communities and classes in South Africa who have experienced sexual violation
CHILD SEXUAL ABUSE AND HIV: 
STUDY OF LINKS IN SOUTH AFRICA & NAMIBIA

Executive summary

Introduction

Over the last few years several countries in Southern Africa have been swept by waves of public outrage and concern about the rape of children. Most commentators perceive the problem to be increasing and there has been considerable speculation its causes. Child sexual abuse is a feature of life in all countries of the world. It is not a new phenomenon in southern Africa, but in the past it has been hidden and largely ignored. The recent publicity given to cases has led to a recognition of the need for research to help understand and stop abuse of children. In order to contribute to the evidence base, Save the Children Fund (UK) and (Sweden) commissioned a desk review and primary research on child sexual abuse and any links with the HIV epidemic in a site in South Africa and in Namibia. This document presents, in its first part, the desk review, which seeks to summarise evidence from South Africa, Namibia, Botswana, Lesotho and Swaziland on the scope and nature of the problem of child sexual abuse and policy responses. The second part of the document is a summary of the methods and discussion of main findings of the two rapid ethnographic studies undertaken in Windhoek, Namibia and a district in north western Mpumalanga.

Summary of findings of the desk review

Scope of child sexual abuse

Following the World Health Organisation’s definition of sexual violence (2002), child sexual abuse encompasses a range of acts including coerced sex, incest, date rape, virginity testing, forced marriage, sexual harassment, and involvement in prostitution and pornography.

Forms of child sexual abuse

Police statistics in most countries provide limited information on the overall magnitude of the problem as only a small proportion of incidents of sexual violence are reported to the police. Data from South Africa show no statistically significant trend in the number of cases reported to the police from 1996 – 2000, although there has been a significant increase in some provinces, most notably KwaZulu Natal. In Botswana there has been an increase in child rape over the 1990s but the rise is proportional to that of rape of all ages.

A nationally, representative sample of South African women found that 1.6% had been raped before the age of 15 years. Studies using a broader definition of child sexual abuse and considering children up to the age of 18 years record a much higher proportion of women as having experience sexual violence in childhood, for example 53.2% amongst school children in Limpopo Province. Abuse of male children is reported in some surveys and infrequently to the police. Rape of girls by groups of men is reported commonly in several countries.

The rape of very young children has been reported over the years in literature from South Africa and Namibia. Although this is frequently said to be a new phenomenon, its occurrence has been documented well before the start of the South African HIV epidemic. It is also reported in many other parts of the world, including the United Kingdom and the Philippines. Its occurrence now cannot be attributed to HIV cure seeking practices.

Presented by proponents as an indigenous response to the HIV epidemic, virginity testing has been condemned by the South African Human Rights Commission and Commission for Gender Equality as a discriminatory cultural practice at odds with the constitution. The scale
of virginity testing is not known but it is undergoing a revival in several provinces, most notably KwaZulu Natal.

There is very little literature on child trafficking and prostitution in the region. These problems are known to exist and are a matter of great concern to responsible agencies.

**Vulnerability**

Most of the data on vulnerability are from South Africa. Sexual abuse is predominantly perpetrated against girls in the second half of childhood (10-17 years). It is a problem for all racial groups and all provinces in South Africa. The review discusses the role of poverty, patriarchy, apartheid and alcohol abuse in risk of perpetration and vulnerability to sexual abuse. The overwhelming factor creating vulnerability of children to prostitution is poverty.

**Circumstances of child sexual abuse**

The most common groups of sexual abusers of children are male relatives, boyfriends and acquaintances and people in a position of power, notably teachers. Stranger rape is recognised but much less common. Sexual harassment in schools by teachers and fellow learners has been recognised as an important problem throughout the region. Date rape is undoubtedly the most common form of severe sexual violence experienced by girls, in particular high levels of forced sexual initiation (15-30%) have been reported.

**Reporting child sexual abuse**

Much child sexual abuse is not reported to adults or the authorities. Barriers include fear of not being believed, of being blamed, shame, fear of the legal processes, anticipated futility of court action, fear of revictimisation, fear of the power of the abuser and many professionals are reluctant to get involved.

**Child sexual abuse and HIV: What are the links?**

Child sexual abuse increases the risk of HIV infection both directly during the abuse and indirectly through impacting on the subsequent behaviour and life experiences of children, for example by increasing the risk of substance use and risky sexual practices. HIV may also increase the risk of child sexual abuse through increasing poverty in families and leaving children orphaned. There is evidence that some men rape children when seeking a cure for their HIV infection. There is considerable debate about the commonness of the belief that HIV can be cured in this way. Most recent national data suggest that this is believed by very few and the number of documented cases of this as a motivator for rape are very few. There is also some discussion in the literature about whether knowledge of HIV infection leads to irresponsible sexual behaviour with deliberate spreading of the virus.

**Legal and policy framework**

A range of international instruments and laws provide the international and national policy framework for handling child sexual abuse in Southern Africa. These are summarised in the report. The greatest emphasis is given to the South African policies. Unfortunately recent hearings held in Gauteng by the Human Rights Commission identified substantial gaps in the operation of these policies and there is general agreement that the services for abused children are hugely under resourced. The only other research on aspects of the effectiveness of the response to child sexual abuse is one study on schools in South Africa.
Research directions

There is a need for research on every aspect of child sexual abuse in Southern Africa. Child sexual abuse has occurred in society throughout history and will not be effectively understood and tackled through short term research strategies. The area deserves the same level of funding, expertise and high quality research as the well established health problems facing our region. There is a clear need for prioritisation of operations research and improving responses to sexual abuse, however a comprehensive research agenda is needed because so little has been established about the magnitude and nature of the problem. Research priorities include:

- the prevalence of different forms of sexual abuse in a range of settings, using where possible standard research tools to enable comparison of findings
- risk factors, both for being abused as a child and sexually abusing children in different ways and the broader social and cultural context in which abuse occurs
- the health and social consequences of different forms of child sexual abuse
- factors influencing recovery of health and well-being following sexual abuse
- evaluation of services and interventions that support abused children or work with abusers
- determining the most appropriate health sector responses to sexual abuse of children including where services should be delivered and by whom
- determining what constitutes appropriate psychological support for different settings and circumstances
- evaluation of programmes aimed at preventing sexual abuse of children, including community-based interventions – particularly those focusing on men – and school-based programmes

Summary of findings of the primary research

Methods: This part of the report described two sister studies which were undertaken to try to understand the relationship between child sexual abuse and HIV and the social context of child sexual abuse in districts in South Africa and Namibia. Both studies followed the same research plan but the fieldwork was organised and research conducted by different researchers. It presents the findings of research undertaken in a district in north western Mpumalanga and Namibia.

Rapid ethnographic methods were used. In Mpumalanga, a total of 30 in-depth interviews were held, with adults from the area (teachers, nurses, social workers, district surgeon, traditional leaders, crèche and NGO workers and men and women from the community) and 9 teenagers participated in three small group discussions. In Windhoek, a total of 47 in-depth interviews were held, 14 with abused girls and boys, 9 with parents/guardians of abused children, 8 with community men and women, and 16 with key informants (teachers, police, social workers, indigenous healers, traditional leaders, NGO staff, priest). Field work was undertaken by a team of Namibian researchers who were either involved with child protection NGOs or social workers. Children who had been abused were identified by Women & Child Protection Unit social workers.

The scope of inquiry included experiences of child sexual abuse, perceptions of its causes or explanations for it, rules regarding adult child relationships, sexual abuse prevention, community perceptions of abusers and abused children and perceptions of services. All interviews and notes were taped & transcribed.

Findings: The term ‘child sexual abuse’ encompasses a hugely diverse set of acts. In the cases series from Namibia, abuse occurred to boys & girls, aged 3-19 years, and the
abusers were mostly relatives, but also family friends, teachers and boyfriends. One was a mother. The abuse occurred in diverse settings, at home, at school, at a friend’s house, in the abuser’s home, public spaces, parties, and at Windhoek show. Some of the incidents occurred once but others were repeated.

In Mpumalanga, it was not possible to interview anyone who was known to have been abused or any family members of abused children. Cases of abuse were described by people who had encountered, or heard of, them through their professional work or community gossip. Most of the interviews included, to a greater or lesser extent, discussions of events in which the informants had not been active participants. This influences the interpretation of the findings, which are perceptions of causes of child sexual abuse and dynamics within the community within which the informants lived as well as perceived barriers to access services. However, a series of cases that people were familiar with was discussed. An interesting range of views was expressed about sexual acts with children which did not constitute abuse, amongst these were a traditional practice of ‘taking snuff’, the sexual abuse of teenagers, sugar daddy relationships and abuse of boys. Clearly local perceptions of the meaning of child sexual abuse different substantially from that of international definitions.

The diverse group of acts which constitute child sexual abuse have multiple causes. The research indicated that there were links between alcohol abuse and poverty and child sexual abuse. Whilst one informant explained “people [both men and women] don’t think when they are drunk”, alcohol abuse by parents was also shown to create vulnerability by driving children from or reducing supervision in the home and to be a vehicle for drugs at parties. Poverty was identified in particular as creating vulnerability to transactional sex work and the prostitution of children.

The responsibility for reducing rape in Mpumalanga was squarely and firmly placed on the shoulders of girls and women and not on those of the abusers or rapists. In the discussion of why rape occurred in Mpumalanga, mothers were widely blamed and fathers scarcely mentioned. Mothers were said to create space for sexual abuse by not taking action against abusing boyfriends or by not supervising their children properly. Similarly girls were expected to demonstrate respect for men, even their father and brothers, by not presenting themselves in clothing would might make them sexually desirable.

Teenage girls were described as inherently sexually desirable in both settings. In Mpumalanga, many of the informants expressed ideas that if men were to become sexually aroused as a result of seeing such a girl, or even by a woman, they would have to have sex and would do so with who ever was convenient. This might be the child who aroused him but it could also be that he was aroused for another reason and a child was a convenient available outlet. Many of the informants spoke of sexually aroused men as out of control and ‘dangerous’. Some of the male informants indicated that if they did not follow such a situation through, especially if they thought they had been deliberately provoked for example by the sight of a miniskirt or G string, they would be seen as weak. For teenage boys to try to rape girls in groups was seen by some as ‘normal boyish behaviour’. In Namibia, there was considerable discussion about the perceived ‘normality’ of sexual desire for girl children and then many forms, including traditional early marriages, in which sex with and sexual desire for children was actually considered to be normal. This was perceived as influencing the prevalence of child sexual abuse.

It was apparent that very little social pressure was focused by parents, families and society on discouraging men and boys from sexually exploiting girls. It was hard to escape the conclusion that child sexual abuse was partly explained as a by-product of an entrenched system of gender hierarchy. Their actions suggested that in many respects it was not seen as a terribly serious thing. In Namibia, the most striking feature of the discussions of
community perceptions of abusers and abused children was the double standards which were applied. Whilst everyone agreed that child sexual abuse was a major problem and abusers were a scourge, many abused children were blamed and even beaten after abuse was disclosed. Many perpetrators were supported by their family, friends and community. Unless society learns to articulate and act upon a clear stance condemning child sexual abuse it will not be possible to substantially reduce the problem.

There was a considerable discussion in Mpumalanga about older men having relationships with teenager girls for money. This was widely recognised but not perceived by most as sexual abuse. There was little apparent social condemnation of these practices and an indication that some mothers may actually encourage them.

Much abuse in Namibia was attributed to the use and abuse of power. Men in positions of authority, such as teachers or police men, were seen as abusing children because they have the power to do so. Some fathers were said to perceive their daughters as possessions and to feel entitled to have their sexual needs met by any of the women at home. Sexual abuse of children was also deployed at times as a punishment or act of revenge, even within the home. Other factors associated with sexual abuse were said to be low self-esteem on the part of the abuser or mental deficiency and experiences in prison.

Poverty was one of the factors which was linked to child sexual abuse. It created vulnerability in children because they were often alone during the day when their parents were working and sometimes were abandoned with inadequate child care arrangements whilst their mother went to work in Gauteng. In discussion of child care fathers scarcely even featured as possible carers. Poverty also influenced the practices of transactional sex although there was general agreement that it was usually not ‘survival’ sex.

Child sexual abuse prevention activities were described in the district as taking place in schools in Mpumalanga. However there was considerable confusion around these. Many people perceived that the message was that all contact between fathers and girl children of a close nature (hugging or kissing) was inappropriate. Many of the people interviewed perceived that the problem of child sexual abuse was so out of control that no mother could trust her husband with children any more. These messages are really counterproductive and will undermine long term efforts to prevent child sexual abuse.

The study explored the broader context of child parent relationships and several informants described the rules of ‘respect’ which govern these. The research strongly suggests that these serve as an impediment to parent child communication and may contribute to child vulnerability as it is difficult for children to discuss sensitive matters with their parents and they reduce parents ability to be alerted to potential situations of risk in children’s lives.

This study was particular interested in ideas about HIV cure myths. None of the informants interviewed believed in these, however, many were familiar with them and had heard people talking about them. In Mpumalanga, none of the service providers interviewed had come across a case. The staff of the Windhoek Women and Child Protection Unit, which saw all cases of sexually abused children, were able to describe one actual case of a man raping his sister’s child due to HIV cure seeking. They could not recall another case, suggesting that this may motivate some child rapes but it is unlikely to be very many.

The services in the district in Mpumalanga did function and people seemed to know how to get help in circumstances of child sexual abuse, but their nature was fragmented and there were many limitations to then. The services in Windhoek were very good in many ways and highly spoken of but they, as those in Mpumalanga, were clearly orientated towards the court system and not the abused children. Staff in both settings identified a number of areas in which they would like to see improvement. The absence of any counselling and
psychological treatment for abused children in the public sector is clearly a major failing of both services. Medical treatment had also not been incorporated into the one-stop centre in Windhoek and resulted in doctors with different levels of training and sensitivity seeing patients. This is a problem in Mpumalanga too. Having specialist trained medical staff who understand about the management of children should be an important feature of a good service. Another gap in the services was the lack of any alternatives for abusers to the court system. The research suggested that many people did not report cases because they did not want the abuser jailed or to have to leave home. If rehabilitation were available it might be an effective way of providing treatment for selected abusers so that the abuse could stop without further impoverishing their families.

**Conclusions:** Child sexual abuse is a very important problem in both communities. Whilst Namibia and Mpumalanga are quite far apart there were many similarities between the findings in the two sites and both complement each other. This report contains many recommendations for preventing abuse and improving services. Most important of all the political will is needed to ensure that child sexual abuse prevention is given the priority it deserves.
PART ONE:

DESK REVIEW

LINKS BETWEEN SEXUAL ABUSE OF CHILDREN AND HIV/AIDS IN SOUTH AFRICA, NAMIBIA, SWAZILAND, LESOTHO AND BOTSWANA

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DESK REVIEW

1. Introduction
Over the last few years several countries in Southern Africa have been swept by waves of public outrage and concern about the rape of children. Most commentators perceive the problem to be increasing and there has been considerable speculation its causes. Child sexual abuse is not a new phenomenon, in the past it has been hidden and largely ignored. The recent publicity given to cases has led to a recognition of the need for research to help understand and stop abuse of children. In order to contribute to the evidence base, Save the Children Fund (UK) and (Sweden) commissioned a desk review and primary research on child sexual abuse and any links with the HIV epidemic in a site in South Africa and in Namibia. This is the desk review seeks to summarise evidence from South Africa, Namibia, Botswana, Lesotho and Swaziland on the scope and nature of the problem of child sexual abuse and policy responses.

Whilst both boy and girl children are sexually abused, evidence suggests that it is mostly a problem of girls and forms part of the spectrum of sexual violence against girls and women of all ages. The World Report on Violence and Health (World Health Organisation 2002) sets the problem of sexual violence in global perspective by discussing the epidemiology, risk factors, health consequences and what is known about effective preventive measures. Whilst this review explores the literature on child sexual abuse in several Southern African countries, the majority of the discussion is framed around South African literature and policy responses as this is the country from which the majority of data are available. This review will start by discussing a definition of child sexual abuse, considering what is known about its prevalence and the forms such abuse takes, circumstances which create vulnerability, barriers to reporting abuse, links between child sexual abuse and HIV, and legislative responses to child sexual abuse. It concludes with research directions.

2. Conceptualising child sexual abuse
There are substantial limitations to most of the definitions of child sexual abuse. The World Health Organisation consultation on child abuse prevention concluded that child sexual abuse should be 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 that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- the inducement or coercion of a child to engage in any unlawful sexual activity
- the exploitative use of child prostitution or other unlawful sexual practices
- the exploitative use of children in pornographic performances and materials”
(World Health Organisation 1999)

This definition, however, does not actually define what constitutes sexual activity or sexual practice. In order to understand this it is useful to look at definitions of sexual violence against adult women. The World Health Organisation’s, World Report on Violence and Health (2002), has a definition of sexual violence against women which can be readily adapted to include sexual violence against boys and to be applicable for children. In the WHO report sexual violence is defined thus:

“any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against, women’s sexuality, using coercion (i.e. psychological intimidation, physical force, or threats of harm), by any person regardless of
The World Health Organisation reports indicate that child sexual abuse encompasses:

- rape and attempted rape – i.e physically forced or otherwise coerced penetration (however slight) of vagina or anus with a penis, other body part or object.
- sexual activity coerced through a spectrum of degrees of force, including psychological intimidation such as threats of violence, of not passing a school year, getting a job or some other form of blackmail or abuse of power; when the child does not understand what is being done through young age and/or early social development, when drunk, drugged or asleep.
- coerced contact between the mouth and penis, vulva or anus
- sexual harassment including sexual humiliation, unwanted sexual contact,
- forced marriage or cohabitation including marriage of children
- prostitution of children
- virginity testing
- female genital mutilation
- participation in pornographic performance or production or materials, or exposure to pornography.

The most common abusers are adult men and boy children, especially in the teenage years. However women may also sexually abuse children and may be co-abusers with men, through assisting men to access children. Sexual violence perpetrated by women is much less visible than that perpetrated by men, but an indication that it is indeed an important problem was given in an analysis of calls to Childline (Cawood 2001) which found that 108 of 962 abusers (11.2%) of early child sexual abuse were women. Older women forcing sex on teenage boys is probably more common than might be expected but is rarely reported as ‘rape’ (Jewkes at al 2003).

3. Prevalence and circumstances of child sexual abuse

3.1 Rape and attempted rape reported to the police

South Africa

The chief source of data on child sexual abuse is from cases reported to the police. Cases are recorded in several categories, most commonly rape and attempted rape, incest and indecent assault. Incidents of child sexual abuse reported to the police are thought to be a small proportion of all incidents of abuse occurring in the country and thus represent the tip of the iceberg of child sexual abuse (Jewkes & Abrahams 2002). Police statistics are therefore of limited use in understanding the prevalence of the problem, however they may be more useful in looking at trends as it is reasonable to assume that the proportion of cases reported changes little from year to year in the absence of interventions around this. Data on reported rape and attempted rape cases are available from 1996 for children. Figure One shows adult and child rapes reported to the police from 1996-2000. There were just under 20 000 child rapes in 1996. The data show modest year to year fluctuations. The relationship between year and number of cases reported was tested using linear regression in the program Stata. This confirmed that there has been no statistically significant trend in the yearly number of cases reported between 1996-2000 (p=0.360, F(1-3)=1.16).
Figure One: Number of rapes reported to the police in RSA from 1996-2000  
Source: CIAC, Dec 2001

Figure two: Number of child rapes (0-17 yrs) reported to the police 1996-2000 by province. Source CIAC Dec 2001

Figure two shows the number of cases of child rape reported to the police by province. In KwaZulu Natal there has been a consistent annual increase in child rape since 1996, this is statistically highly significant ($p=0.0043$, $F(1-3) = 62.18$). In Mpumalanga there has been a rise in reported cases for 1999 and 2000, this is also statistically significant ($p=0.05$, $F(1-3) =$
10.2) In none of the other provinces has there been a change in the number of reported cases which cannot be explained by random variations or chance.

Figure three shows the proportion of all rapes and rape attempts of children (i.e. under 18) where they were under 12 years. Data are only available from 1999. Over this period in the country as a whole, just over a third of child rapes and rape attempts were against children under 12 years. There was no change over the three years. A consistent increase was found in KwaZulu Natal and the Western Cape. A consistent decrease was found in Gauteng and the Free State and there was no clear trend in the other provinces.

**Figure three: children under 12 years raped as a proportion of all child rapes (1999-2001)**

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**Botswana**

Data on children rape are very limited in Botswana. A 1998 report, produced by the Emang Basadi Women’s Association, stated that in 1997 1183 cases of rape were reported to the police. It is not clear what proportion of these were children. A report on rape commissioned by the Botswana Police Service (Procek 1999) analysed 1194 cases of rape, attempted rape, defilement of persons under 16 years and of ‘imbeciles’, indecent assault and incest from 25 police stations occurring between 1996 and 1998. In these cases, 2.3% of abused children were under 6 years, 4.8% were 6-10 years and 18.3% were 11-15 years. 50.7% of all abused children were aged 11-20.

As in South Africa, there have been concerns in Botswana that the number of rapes of children were rising disproportionately to that of older women, with the suggestion that this could be linked to HIV prevalence. The increase in child rape, however, is proportionate to
that for all rapes. Another interesting finding was that the majority of men who rape children are young themselves, aged 22 and under (Procek 1999).

Swaziland
Data on rape cases are available from the police. In 1998 649 cases were reported but they do not disaggregate their data by age (Mthetwa and Dlamini 2000).

Namibia
Data on rape cases reported to the police are available but are not routinely disaggregated by age. The absolute numbers increased throughout the 1990s from 564 in 1991 to 714 in 1998, an increase of 21%. However the country's population grew by more than 50% over the same period (UNDP 2000). These figures for rape cannot be interpreted without adjusting for the underlying population growth and changes in the age structure of the population, the data are not available to the author at the time of writing to do this. Between January –October 2002, 124 juvenile (0-17 yrs) criminal cases were reported to the Women and Child Protection Unit in Namibia. 119 (96%) were complaints of rape, attempted rape or incest against girls and 5 (4%) were of rape of boys. Eleven of the 119 cases (9.2%) were of girl children aged 0-5 years, 23 (19.3%) were of 6-10 year olds and 84 (70.6%) were of 11- 17 year olds. One girl's age was unknown. Three of the boys were 6-10 years and two were 11-17 years.

3.2 Survey findings on forced sex
South Africa
National survey data on child sexual abuse are available from the 1998 South Africa Demographic and Health Survey (Jewkes et al 2002). This was a nationally representative study of 11,735 women aged 15-49 years, who were asked about their experiences of having been as ‘forced or persuaded to have sex against their will’ before the age of 15 years. This survey found that 1.6% (1.2%-1.9%) had been raped. 85% of the rapes occurred between the ages of 10-14 years, and 15% between 5-9 years. These figures may reflect a well-described problem of recall failure in children raped before the age of 5 years. Statistical modelling showed that younger women were significantly more likely to report rape to a survey interviewer than older women. It is not possible to know whether this is a result of recall bias. The prevalence of childhood rape by the 15-19 year olds was 3.1% (95% CI 2.2 –4.0).

There have been several surveys of school students which inquired about child sexual abuse, for example Madu and Peltzer 2001, Madu 2001 and Madu & Peltzer 2000 in the Limpopo Province. Studies which use a broader definition of child sexual abuse get very high prevalence rates reported. Unfortunately studies vary on definitions of sexual abuse, questions asked and research methods followed so that comparability between them is difficult. One of the larger studies was the national study of school-going youth in 9 provinces (n=9300) was conducted by Myburgh (2002). They were aged 12-21 years. Of the women, 7% from rural schools, 5% from urban and 3% from urban-metro schools reported having been forced to have sex without permission in the previous year.

Madu and Peltzer (2000, 2001) found 54.2% of their sample (n=414) of Limpopo Province school students reported physical contact forms of sexual abuse with an adult or person at least 5 years older or a person in a position of power. 60% of males and 53.2% of females reported this. Abuse included sexual kissing (86.7%), being touched sexually (60.9%), and oral/anal/vaginal intercourse (28.9%). The most common abuser was a “friend”. Only 13.3% of children who the researchers categorised as abused perceived themselves to have been sexually abused. Pedi children were less likely to be abused, and increased risk was associated with having a mother who worked but not as a labourer, a step-parent at home in childhood and often having violence at home (Madu and Peltzer 2000).
Dunkle et al (in press) undertook a cross-sectional study of women attending antenatal services in Soweto. 1395 women were interviewed, aged 16 - 44. They were asked about being touched sexually or forced to touch a man sexually before the age of 15 years, 5% (70) responded that they had experienced this, 2.9% had experienced it once and 2% more than once. 5% (69) responded that they had been raped before the age of 15, 3.3% experienced this once and 1.7% more than once. 6.2% (85) reported before “forced” at sexual initiation and a further 6.2% (86) reported described their sexual initiation as “rape”.

Namibia
A survey of women’s health and domestic violence was conducted amongst women in Windhoek as part of the WHO multi-country study on violence against women. Interviews were conducted with 1503 women. They were asked about experiences of sexual initiation. 33.3% (20) of those reporting sexual initiation prior to age 15 described the experience as ‘forced’ and 5.7% (25) of those aged 15-17 years at the time of sexual initiation (Rose Junius H, personal communication).

3.3 Sexual abuse of young children
There has been considerable recent public outrage over incidents of rape of babies and very young children reported in the media. There are insufficient data to indicate whether this problem is increasing but staff involved in child protection have expressed a view that this is the case and that incidents are becoming more brutal. Two questions can be addressed in this report: is this new? And is it a unique South African problem?

The answer to the first question is ‘No’. Child sexual abuse in the 1980s has been documented in a review of cases seen at the Child Abuse and Neglect Clinic of the Transvaal Memorial Institute from May 1988 to April 1989 (de Villiers & Prentice 1996). This shows that sexual abuse, including rape of infants and toddlers, is not a new phenomenon in South Africa. Over the period reviewed, 227 patients were seen at the clinic, 80% were female and 89% of all patients presented with a complaint of sexual abuse, which included fondling of body, fondling of genitalia, forced observation of pornography, forced observation of intercourse, mutual masturbation or anal or vaginal intercourse. Under the age of 10 years, 31 girls and 5 boys were proven to have been sexually abused, 23 girls and 3 boys had signs ‘highly suspicious’ of sexual abuse, and 26 girls and 9 boys were determined to be cases which were ‘unproven’ but still suspected abuse. They further report that 11 of 12 girls under 3 years, 34 out of 42 in the 3-6 year age group and 35 out of 39 in the 6-10 year age group suffered sexual abuse of some form. In all, 7% of children in their sample were under 3 and suffering from sexual abuse.

The question as to whether rape of young children is unique to South Africa can be answered by review of international literature. This shows that it is not unique. For example a paper published in 1995 described signs of vaginal penetration in 109 English children, the mean age of which was 5.8 years (Hobbs et al 1995). In another paper reporting on another series of English child sexual abuse cases, they report that the most cases occurred between 2 and 7 years. Four children in their series died, and sexual abuse and death were linked (Hobbs & Wynne 1990). In another example an article written by a priest in the Philippines, Father Shay Cullen describes several cases of rape of babies by their fathers and other men (Cullen 1997). Cases of rape of children as young as 17 months old have been reported in Namibia (UNDP 2000). It is possible to identify cases of baby rape from all corners of the globe, although of course this does not detract from the appalling nature of South Africa’s cases.

3.4 Gang rape
Approximately a third of cases of rape reported to the police in South Africa involve two or more perpetrators (Martin 1999). In these cases the people raped are usually children or young adults. Research on gang rape indicates that there are two forms. The first is
opportunistic rape of women by groups of men, who may or may not see themselves as a formal gang, but often associate themselves with a tsotsi lifestyle. This is described by Wood (2002) in Umtata and most memorably by Mokwnena (1991) in writing about the ‘jackroller’ gang which terrorised residents for Soweto during the 1980s. The latter gang often picked girls as targets who were inaccessible to them as girlfriends or who they thought behaved as if they were better then them. Another group of women and girls who are often targets of this type of activity are those who get very drunk in shebeens, at parties or other public places. Gang rape in this context was described by Wojcicki (2000).

The second type of gang rape which particular affects teenage girls is known as ‘streamline’ or ‘istimela’ (train) and usually involves rape of a girl by her boyfriend and his friends. An indicator of the frequency of participation in this comes from a small survey of men (n=122) participating in sexual health promotion workshops in Winterveldt, north of Pretoria. Asked ‘have you ever done streamlining or had sex with a woman who was really drunk, together with a group of friends?’, 16% that they had. The only difference between those who had and had not been involved in gang rape was that the former group drank more alcohol (Wood et al 2002). In research with a similar group of young men (n=150) from the Eastern Cape, 8.3% reported participation in streamlining before the age of 18 years (Jewkes et al 2003).

In Umtata, Wood found that streamlining was often ‘organised’ by a man for his girlfriend as a way of ending the relationship when he is ‘tired’ of her because surely she will not come back to him after this has happened; or to ‘teach her a lesson’ when she has been sexually unfaithful, or if she is behaving in other ways which undermine him. It could also happen when a young woman refused a man’s attempts to make her his girlfriend or she refused him sex. The practice aims to discipline the woman and to ‘take away her timing’ (timing is a slang term denoting a certain desirable kind of confidence and ability to be quick thinking)—thus to humiliate her (Wood et al 2002). Gang rape is reported in Namibia in very similar circumstances to those of South Africa (UNDP 2000, p.101-3).

3.5 Virginity testing
The World Report on Violence and Health (2002) includes virginity inspections in its definition of sexual violence. There has been considerable debate about this area in South Africa in recent years in the wake of a revival of interest in virginity inspections in certain communities and a parallel response from the Human Rights and Gender Commissions and other gender advocates. In June 2000 The Commission for Gender Equality and the South African Human Rights Commission had a consultative conference on virginity testing, concerned that since only girls were involved it was a discriminatory cultural practice which was at odds with the Constitution (CGE 2000). Their conference was preceded by a period of research. Leclerc-Madlala (2001) has also undertaken ethnographic research on virginity inspection in KwaZulu Natal and there have been reports of the practice in the Eastern Cape and Mpumalanga. Virginity testing is also carried out in Swaziland. It is not known how widespread the practice is or how many girls undergo this each year. Figures of 60-65,000 girls tested are cited but there is no system for counting (CGE 2000).

Leclerc-Madlala (2001) argues that virginity inspections have been described at least in Zulu and Xhosa culture as a occurring prior to marriage to determine the level of lobola. Although some people today claim girls were once routinely subjected to virginity inspections, it is not clear that this was indeed the case. That young girls developing bodies were an object of wide social interest is not in doubt. The practice of ukushikila, whereby a girl was expected to raise her skirt and expose her lower abdomen, back and front upon the command of any adult family member is an example of this. Along with the widening hips which indicated sexual maturity, flabby stomachs and ‘loose’ buttocks were said to be signs of lost virginity. Other signs of lost virginity which modern day virginity inspectors look for
include loose hamstring muscles (behind the legs), a look of lost innocence in the girl’s eyes, dark coloured and moist labia, cuts or bruises on the external genitals, pimples, sores or a foul smelling discharge, size of the vaginal opening and an absence of a white dot or white lacy veil deep in the vagina. These ‘indicators’ of virginity are similar to those described to Wood (2002) in Umtata by older women. Virginity testing is being practiced on girls as young as 6 years old – as one tester explained in a letter to the Natal Witness this was because by the age of 12 half the girls tested had already lost their virginity because they were being abused by their relatives (The Natal Witness, letter to the editor, July 20, 2000, cited in Leclerc-Madlala 2001).

Critics of virginity testing point to the disjunction between the signs of virginity looked for by testers and medical indicators of penetrative sexual intercourse, but their chief concerns relate to human rights implications of virginity testing (CGE 2000, Leclerc-Madlala 2001). Virginity Testing violates article 10 of the African Charter which states that no child should be subject to arbitrary or unlawful interference with his/her privacy or attacks on his/her honour or reputation (CGE 2000, p.28). Leclerc-Madlala (2001, p.536-7) argues “examining girls to determine their virginity status is another thread to reinforce a web of meaning that places women and women’s sexuality at the epicenter of the current AIDS epidemic”. The Gender and Human Rights Commissions argue that the practice is counter to stipulations in the national constitution that uphold rights to privacy, bodily integrity, and outlaw all forms of gender discrimination. That it is a form of gender discrimination is evident as men are not subjected to the same inspections and virginity testing is based on a premise that women are responsible for society’s morality (CGE 2000).

Although virginity testing is often depicted as a harmless indigenous response to AIDS that girls are proud to participate in, most girls are sent for the test by their mothers, have it at school, church or at work and are not in a position to make a truly voluntary decision. Codes of respect would preclude girls from refusing their mother’s or teachers’ instructions. Those determined not to be virgins are marked with shame and disgrace, referred to as ‘prostitutes’ [izeqamgwaco] (CGE 2000) or ‘rotten potatoes’ who will corrupt the real virgins if not kept away from them (Leclerc-Madlala 2001). In some areas the girl’s father is fined by the chief for ‘tainting’ the community.

3.6 Child sexual exploitation and trafficking
There is very little literature on child prostitution and trafficking of children for sexual exploitation in the region, the number of children sexually exploited in these ways is not known. The issue has been highlighted in South Africa in Special Assignment television documentaries and in a report by the non-governmental organisation Molo Songololo (2000). The report was based on a desk review, review of newspaper clippings, and interviews with girls and professionals, such as police and social workers.

Molo Songololo (2000) found that most of the prostitution described was of girls. The circumstances in which this occurred varied. In some cases people linked to gangs or syndicates forcibly recruited children to work in the sex industry from brothels or on the street. There is some evidence of organised crime syndicates trafficking children into South Africa from other countries including Russia, Thailand, Taiwan, Mozambique and Angola. Some newly established business ventures advertise in newspapers for girls to work in the hospitality or film industry, which turns out to be work in the sex industry. Children already in the sex industry were also identified as involved in recruiting siblings or friends into brothels and escort agencies as well as massage parlours and exotic dancing. Families at times coerce children to work from their home or the homes of sex exploiters. One example of this is when children are sent to work as ‘surrogate wives’ for a family acquaintance or person in authority, cooking, cleaning and are sexually assaulted.
Thus formal sex work and trafficking are only part of the spectrum of sexual exploitation which is found in South Africa. Informal sexual exploitation, often couched within the notion of 'sugar daddy' relationships is much more common and falls squarely within the definition of sexual abuse of children. Whilst exchange and present giving is a feature of sexual relationships of all ages, where the relationship is between an adult and a child this has quite different connotations. Research by the HSRC (Schurink & Schurink 1996) concluded that the majority of sexually exploited children are girls and the majority of exploiters are men, boys but, increasingly, women. Children are often paid ‘in kind’ for sex, receiving shelter, food, school fees, or new clothes in return for sexual favours. Whilst most transactional sex is not ‘survival’ sex in a true sense, those adolescent girls and boys who have no other means of supporting themselves and/or their families have been found to regard sex as an acceptable way to earn money.

4. Vulnerability to sexual violence

4.1 Risk factors from the international literature

There is limited Southern African research on factors related to vulnerability to child sexual abuse. In understanding these, however, it is useful to look at the international literature on factors which increase men’s risk of committing rape. The factors associated with increased risk of rape are shown in Figure Four. Rape causation should be thought of as multifactorial: the more risk factors present the greater the likelihood that an individual will be sexually violent (World Health Organisation 2002).
**Figure Four: factors increasing men’s risk of committing rape**

**Individual Factors**
- Alcohol and drug abuse
- Coercive sexual fantasies and other attitudes and beliefs supportive of sexual violence
- Impulsive and antisocial tendencies
- Preference for impersonal sex
- Hostility towards women
- History of sexual abuse as a child
- Witnessed family violence as a child

**Relationship factors**
- Associates with sexually aggressive and delinquent peers
- Family environment characterised by physical violence and few resources
- Strong patriarchal relationship or family environment
- Emotionally unsupportive family environment
- Family honour considered more important than health and safety

**Community factors**
- Poverty mediated through forms of crisis of male identity

**Societal factors**
- Societal norms supportive of sexual violence
- Societal norms supportive of male superiority and sexual entitlement

(source: World Health Organisation 2002, p.159)
4.2 Risk factors from the local literature

Age
Rape and other forms of sexual violence affect children of all ages, however evidence of surveys and police reports indicate that the ages of greatest risk are from 10-17 years.

Sex
Both girls and boys experience child sexual abuse but the police statistics suggest that it is much more common in girls than boys. There is very little research on child sexual abuse in boys.

Race
The South Africa Demographic & Health Survey (Jewkes et al 2002) clearly indicates that child sexual abuse is a problem for all groups within South Africa. Multiple logistic regression model fitting showed that race (based on the apartheid-defined population categories) was significantly associated with reporting child sexual abuse. White women were more likely to disclose rape than African women. The odds ratio for white women was 2.57 (95% CI 1.14 – 4.57) compared with Black African women, after adjusting for the effect of province and age.

Province
National data on vulnerability to rape in childhood are available from the South Africa Demographic & Health Survey (Jewkes et al 2002). Multiple logistic regression model fitting for sexual abuse showed that educational status and urban/rural residence were not associated factors but race (based on the apartheid-defined population categories), province and age cohort were. Women in the Northern Cape, Free State, and North West were significantly less likely to disclose rape than women in the Western Cape (adjusting for the effects of race and age). Younger women were more likely to disclose than older women (Jewkes et al 2002).

This pattern however is not the same as that reflected in the more contemporary police crime statistics, where the age groups are also slightly different. Figure Five shows that the Western Cape, Northern Cape and Gauteng have the highest rape of child rape per 100 000 female population.

Figure Five: Rate of child rape (under 18s) per 100 000 female population by province in South Africa
Poverty
Poverty renders girls vulnerable to rape in the course of their daily tasks – whether walking home from school, or collecting water or firewood. Children of poor women may have less parental supervision when not in school, since their mothers may be at work and not able to afford child care. The children themselves may, in fact, be working and thus vulnerable to sexual exploitation. Not only does poverty force some girls into sex work, but girls in sex work are at considerably heightened risk of sexual violence. Poverty also creates enormous pressures for girls to obtain good grades or not repeat school years and incur fees again – all of which renders them vulnerable to sexual coercion.

Molo Songololo concluded that children were vulnerable to sexual exploitation from 4 years old. They had often experienced sexual abuse, other forms of child abuse and domestic violence in their home. Many child sex workers have run away from home because of abuse or leave home to search for missing parents or work because there is insufficient money at home. They have all been manifestly failed by society, their families and social welfare services (Molo Songololo 2000 p.31).

Poverty has been associated with perpetration of sexual violence and several authors have suggested that this is mediated through a crisis of masculine identity. Men feel pressurised by ideals of masculinity linked to providing for families which are unattainable in a context of high unemployment and few opportunities for youth. In this context “successful” masculinity is redefined centring on sexual conquest and control of women as men turn their aggression on women who they can not control patriarchally or support economically. Acts of violence against women serve to reaffirm a sense of male powerfulness which is otherwise denied (Wood & Jewkes 2001, Wood 2002).

Alcohol abuse
Alcohol use and abuse is associated with child sexual abuse in multiple ways. However, many people drink alcohol without abusing children and many people who abuse have not had alcohol when they abuse children. Child sexual abuse cannot be blamed on alcohol, nor can drinking to be used as an excuse. None the less many child rapists are drunk (Wood 2002). Girls who drink alcohol are at greater risk of being raped (Wojcicki 2000, Wood 2002) and there is some evidence that parental drunkenness renders children vulnerable to sexual abuse by others. In several of the recent cases of baby rape in South Africa the mother of the child had been drinking. The links between alcohol and risk of abuse are a result of the social context of alcohol consumption in South African society. Particular problems arise from drinking to excess, drinking environments outside the home, male bonding around drinking, perceptions that women who drink alcohol are loose and associations between alcohol drinking and violence.

Patriarchy
Girls in Southern Africa are rendered vulnerable to sexual violence because of the patriarchal nature of Southern African societies (Wood & Jewkes 2001; Wood 2002; Becker 2000). Control of women has been identified as a central theme in ideas of ‘successful’ masculinity which are quite prevalent amongst southern African youth. Physical and sexual violence are used by many men to enforce hierarchical social relations. Key ideas within hierarchically structured gender relations include male entitlement to sexual access to any woman that they can succeed in accessing and women’s responsibility for guarding their virtue. Whilst Wood (2002) found that most men would not claim that rape was a practice of ‘real men’, the majority of coerced sex described to her was not perceived as ‘rape’ by the men involved. Sexually violent men tend to have an exaggerated sense of masculinity, are more hostile towards women and regard them as opponents to be challenged and conquered (WHO 2002).
In Botswana child sex abuse has been linked to patriarchal customs (Rantona K: personal communication). Historically sex with young girls was sanctioned through arranged marriages of young women, this practice has changed but the perception that it's good for an older man to have sex with a young girl has remained. Girls are often told as they grow up that it is alright for a girl to have sex with her uncle (“setlogolo ntsha ditlhogo”), thus this activity is not traditionally seen as abusive (Rantona K: pers comm.).

Apartheid and the legacy of violence
There is not much local literature on relationships between South Africa’s apartheid past, the violence of South African society and child sexual abuse. However some links can be established. The gang culture which prevails in many South African townships and in prisons is part of the legacy of survival strategies developed in the face of disenfranchisement, disempowerment and poverty. Sexual aggression is often a defining characteristic of manhood in male gangs (Petty & Dawson 1989) and men with sexually aggressive peers are more likely to coerce sex both within and outside the gang context (Gwartney- Gibbs et al 1983).

Childhood environments that are physically violent, emotionally unsupportive and characterised by competition for scarce resources have been associated with a greater risk of sexual violence perpetration (Gwartney-Gibbs et al 1983, Malamuth 1998). Part of the pathway of risk is thought to be though the impact of such childhood environments on men’s ability to form close emotional relationships with women (WHO, 2002). The systematic disruption of families caused by the apartheid laws and impoverishment of the black population created circumstances which could contribute in this way to increased risk of sexual violence perpetration. Research on these issues in South Africa is urgently needed.

5. Circumstances of coerced sex
The South Africa Demographic & Health Survey asked women about rape in childhood and who perpetrated this. School teachers were the most common child rapists, responsible for 33% (95% CI 23%-42%) of rapes. Relatives were also a major group (21%), as were strangers or recent acquaintances (21%) and boyfriends (10%) (Jewkes et al 2002). These data highlight important groups of people who rape children, although the distribution of these over the full spectrum of childhood years (i.e. 0-18) would be slightly different as date rape is more important in older age groups. It is difficult to know the relative importance of different perpetrators of child rape because the picture is blurred by differential likelihood of rape by people with different relationships to the victim being drawn to the attention of authorities, disclosed in surveys or hidden deeply and never revealed.

Sexual violence as an abuse of power
The South Africa Demographic & Health Survey data show that approximately 1 in 200 South African women aged 15-49 years were raped by a school teacher before the age of 15 (Jewkes et al 2002). Sexual harassment by teachers has been repeatedly documented in studies in South Africa and in research in Botswana (Rossetti 2001). A survey of 600 students in North West Botswana found that 67% of students had experienced sexual harassment by teachers including unsolicited touching, patting, pinching, dirty jokes, sexual innuendoes, pressure for dates or whistles. 20% of students reported having been asked for sex by teachers. Of these 42% accepted and 62% of these said it was because they feared the teachers. Acceptance of propositions was highest amongst Form One students as compared with Form 5 and 85% of these students cited fear as the reason, compared with 20% on Form 5.
Research in South Africa (Brookes 2001) shows a similar picture, with a perception from case studies that girls in high school were equally at risk of rape the community as in high schools. Male learners and educators were both reported to threaten and use violence against girl learners and young boys reported sexual harassment from older boys.

_Date rape_

Date rape is undoubtedly the most common form of severe sexual violence experienced by girl children. Studies of adolescents have found a high proportion of young women describe forced sexual initiation, as well as subsequent sexual coercion by their partner. This was reported by 28% of a sample of Transkei school students (Buga et al 1996) and 28% of a random sample of young women from Khayelitsha, Umlazi and Soweto (Richter 1996). A case control study of teenage pregnancy in Khayelitsha found that 30% of pregnant teenagers reported forced sexual initiation and 18% of the age-matched, never pregnant, control group (Jewkes et al, 2001).

Research indicates that whilst date rape is a major problem for adolescent girls they distinguish it from ‘rape’ (Wood 2002). It is thus rarely reported to the police and is not reported in surveys on rape unless specific questions are asked to elicit it. For example, Jewkes et al (2001) found that at the time of interview (mean age 16.5 years) 11% of cases and 9% of controls said they had been “raped” but 72% of cases and 60% of controls reported being forced to have sex against their wishes (including at initiation of sexual activity). Although the data are from a non-probability sample and were collected in part of one city, they suggest that experiences of non-consensual, sexual intercourse, could be very common indeed.

_Sexual abuse in families_

Sexual violence against children within families was highlighted in the South Africa Demographic & Health Survey, with 21% of abusers reported to be relatives (Jewkes et al 2002). The series from the Transvaal Memorial Institute (de Villiers & Prentice 1996) further highlighted vulnerability within families. Most of the children in their series had experienced chronic, on-going abuse and abusers were family members in 66% of cases and strangers in only 7%. The most common family members were biological fathers (22.7% of all cases), mother’s boyfriends (11.4%) and stepfathers (9.9%). These figures are very similar to the child rapists in Swaziland described by Mthetwa and Dlamini (2001).

6. Reporting child sexual abuse

A considerable amount of research has been undertaken around barriers to reporting rape to the police and disclosing sexual violence to interviewers in surveys. In general, different forms of sexual violence will be disclosed in surveys if appropriate questions are asked, in particular the dating-associated rape including forced sexual initiation, which is rarely reported to the police. The barriers to reporting rape to the police faced by women and girls of all ages are discussed in detail elsewhere (Jewkes & Abrahams 2002) and summarised, with other barriers in Figure Six. The South African Human Rights Commission Report highlights the role of these as barriers to those to reporting child sexual abuse to authorities (SAHRC 2002, p.17). Most of the data on reporting barriers are from South Africa, but similar barriers would be expected in the other countries.
FIGURE SIX: BARRIERS TO CHILDREN AND ADULTS REPORTING CHILD SEXUAL ABUSE TO AUTHORITIES

- fear of not being believed or being accused of lying
- feelings of shame, guilt, humiliation and embarrassment on the part of the child
- feelings of pity and love towards the person abusing
- problems of physical access to police or social workers
- fear of retaliation or intimidation by the abuser especially when combined with a lack of confidence that the legal process will result in a conviction
- fear of the legal processes including experiencing rudeness and poor treatment by the police
- fear of having to relive the trauma in court and during the investigation
- fear of upsetting the stability of the family
- fear of the power and authority of the abuser
- fear of loss of economic support of abuser
- preference for payment of ‘damages’ from the abuser
- fear of ostracism or ridicule by peers if a complaint is made against a teacher or fellow pupil
- experience of lack of interest from adult to whom the disclosure is made
- mother’s jealousy of child who is having sex with father
- lack of understanding of power dynamics of incest and intergenerational sexual relationships
- reluctance of professionals to get involved because of the time it takes
- desire to avoid stigma associated with being raped (label as ‘damaged’)

A particular barrier to reporting cases of child abuse, which has been highlighted in the work of Wood in Umtata (2002) is that rapists may be very affectionate to girls after raping them. She describes this in the case of a school teacher who raped a pupil, but the same consideration is sometimes pertinent to incest. This may generate very confused emotions in the abused girls. It is not uncommon to hear that girls become the girlfriend of their rapist, especially with rape by teachers, this may be explained by acts of affection which accompany the rape as well as a view that this avenue ‘saves face’ by avoiding the blame associated with rape and the stigma.

Health care providers describe further barriers to reporting incest. In rural Eastern Cape, for example cases are often discussed at family meetings before a decision is taken to report them to the police (Linda: personal communication). The same situation is reported in Namibia (Damases et al 1999). Particular pressure is exerted not to report in situations where the abuser is a breadwinner in a family. Often the family decides that they would rather accept financial compensation for a rape (‘damages’) rather than pursue a case. The societal tendency to blame girls for sexual abuse can create another barrier to reporting in families. Mthethwa and Dlamini (2000) describe mothers becoming jealous of their daughters who were having sex with their fathers, assuming that the daughters were enjoying it.

Limited geographic access and limited capacity are overwhelming barriers to reporting of child sexual abuse to non-governmental organisations, community-based organisations and social workers. Even though Childline is accessible by phone access to phones in many areas are limited and many people would not know the number. Most non-governmental organisations and community-based organisations do not advertise as widely as they could because they lack the capacity to respond to the demand which would be thus generated.
Community-based lay counsellor projects, like that operated from Masisukumeni Women’s Crisis Centre in Mangweni, Mpumalanga, are important in improving access in rural areas.

The SA Human Rights Commission (SAHRC 2002) hearings on child abuse heard evidence of professionals not complying with their duty to report suspected cases. Teachers and principals were said to not want to get involved with sexual abuse cases, ignoring incidents reported to them or simply referring abused children to the police without reporting the matter themselves. At least one Child Protection Unit gave evidence that they rarely have cases reported by medical and nursing staff, despite statutory obligations. The Human Rights Watch Report (2001) confirmed these findings. It reported that schools devalue reports by children of sexual harassment and rape, often responding inappropriately or failing to respond. This discourages children from making complaints. Fear of ostracism or ridicule by peers after making a complaint was a further barrier identified in schools.

7. Child sexual abuse and HIV: what are the links?

7.1 Child sexual abuse increases risk of HIV infection

*Directly during the abuse*
HIV may be acquired through any act of vaginal or anal sex, and with a lesser probability oral sex, with an infected person without a condom. The risk of transmission is greater in sex with a child because of the child’s small body size and thus increased likelihood of injury. The exact risk from a single act of child or adult rape by a man of unknown HIV status is not known and will depend on the likelihood that the man had HIV, whether he ejaculated, had another sexually transmitted disease, the extent of injuries and his viral load. There is a case series from Red Cross Children’s Hospital in Cape Town of children raped between 1990 and 2000, 1% of the children raped sero-converted although from 1997 all received anti-retroviral prophylaxis (van As et al 2001).

*Through the impact of child sexual abuse on subsequent behaviour and life experiences*
Children who experience sexual abuse are a greater risk of behaviours and life experiences during adolescents and adulthood which are associated with a higher risk of becoming infected with HIV. These include starting sexual relationships at an earlier age, drug and alcohol abuse, trading sex for money, having more partners and not using condoms (World Health Organisation 2002).

Research by Dunkle et al (in press) shows that children experiencing sexual abuse and forced sexual initiation have a much greater risk of experiencing intimate partner violence in adulthood and experience it at a younger age. Intimate partner violence is associated with a significantly greater risk of HIV infection. The health impact of forced sexual initiation is also shown in research on teenage pregnancy among younger teenagers (up to 18 years). It is associated with a very much greater risk of later teenage pregnancy after adjusting for other risk factors (risk ratio 14.0) (Jewkes et al 2001).

This long term increased risk after child sexual abuse is thought to be mediated through impact of child abuse on perceptions of control over sexuality and long term psychological consequences, including depression and post-traumatic stress disorder. Further research is needed.

7.2 HIV infection as a cause of child abuse

*Through increasing poverty*
HIV infection could be linked to an increased risk of sexual violence against children in some circumstances. If parents are infected with HIV and home circumstances deteriorate as they become ill or die, children may be prostituted to survive or may find the deepening poverty
forces them to engage in activities in which rape is a considerable risk such as staying out late hawking.

HIV may also be related to future increases the likelihood of men being sexually violent. There is strong evidence that harsh childhood environments play an important role in shaping male tendencies towards sexual violence through reducing men's abilities to engage in loving sexual relationships (Malamuth 1998). Poverty increases the risk of involvement in violent adolescent peer groups which flourish in urban and rural slums. The AIDS epidemic is increasing the poverty of many children's households and orphaning denies many children loving relationships with parents. Research is needed on the extent to which boys emotional needs are met in their care environment after the death of parents.

Men seeking younger partners
HIV fear may drive men to search for younger partners who are less likely to be infected. This has been described by Leclerc-Madlala (1997) and Mthethwa and Dlamini (2000), but whether behaviour has actually changed in this way is not known. The perceived sexual desirability of young women is certainly not a new phenomenon in the region (Neihaus 2000, Rantona, personal communication).

Child rape when seeking an HIV cure
The belief that having sex with a virgin can cure a man of HIV has been reported from many countries in Sub-Saharan Africa. The myth is rooted in indigenous ideas of illness and healing (Jewkes & Wood 2000, Leclerc-Madlala forthcoming) which conceptualise illness as a state of bodily dirtiness (pollution) and healing as involving processes of cleansing (removing physical, magical or ritual dirt). Having sex with a pure virgin is thought to remove the dirtiness (disease) from the man's body. How extensively the idea is believed and whether having sex with a virgin is recommended by indigenous healers is a subject of considerable debate (e.g. UNDP 2000, p. 103).

The belief that having sex with a virgin can cure HIV has been explored in a study in the Daimler Chrysler plant in East London. The authors reported that 18% of employees believed it (UNISA 2001). Leclerc-Madlala (1997) described it as a “highly prevalent” idea based on qualitative research in KwaZulu Natal. However, large scale national research does not indicate that it is a widely held belief. The study, undertaken in 2002 by the HSRC, MRC and CADRE to determine national HIV prevalence and behavioural risks, asked respondents to indicate whether they agreed, disagreed or did not know of the belief. Amongst 7 089 respondents aged 15 years and over, 1,6 per cent had specific convictions that AIDS could be cured by sex with a virgin, while 10,1 per cent did not know (HSRC 2002).

There have been isolated cases where men are known to have abused children in the course of seeking an HIV cure. Luke Lemprecht, the manager of the Transvaal Memorial Institute clinic in Johannesburg is on record as having identified a case where a mother sold her 4 year old child to a man for this purpose [Pretoria News 6.12.2001]. He mentioned to the reporter that it was the only case he had come across. A case has been reported by social workers in Namibia (Rose-Junius, personal communication). Although the practice of 'virgin cleansing' is much discussed and obviously happens there is no evidence yet to suggest that it is common. Some of the most publicised 'cases' have been shown to have been motivated by much more mundane instincts, notably revenge in the case of Baby Tshepang for the mother ending a relationship with her boyfriend.

Caution is advised before identifying this 'myth' as an area for intervention – apart from taking strong action against anyone who is found to propagate it or act on it. The possible
negative consequences of such an intervention in the form of a public education campaign include spreading the myth in quarters which have not already heard of it or unwittingly inciting people to act on it. Some researchers have found that many of the people they have worked with have never heard of the virgin cleansing idea (Wood K, personal communication). These sorts of consequences are recognised in the context of other health promotion interventions internationally.

Despite these uncertainties, the possibility of people wanting to rape virgins to cleanse themselves has been raised as a concern around virginity testing in the Commission for Gender Equality Hearings (2000). Knowledge that a girl is a virgin could place her at increased risk of rape either for this reason or as a target for young men who like ‘in accessible’ girls. This could result in a paradoxical situation where children undergoing this practice in the name of reducing HIV risk may be in fact placed at heightened risk.

“I don’t want to die alone”
Leclerc-Madlala from Durban (1997, 2000) published work discussing the idea “I don’t want to die alone” as a factor influencing rape. There have been several newspaper articles from other parts of the country which have suggested that certain gang members, once they have discovered they have HIV have set out deliberately to infect other people. This may be through unprotected sex and not rape. There is no data to indicate how common these ideas are and how often they are put into practice. Leclerc-Madlala wrote that most of the young people she interviewed in Durban assumed that they had HIV and told her they acted from that assumption. This idea was also explored in unpublished research by CIET-Africa (Myburgh 2002). A national study interviewed 9300 youth in all nine provinces using a self-administered questionnaire. Asked if they would intentionally spread HIV if they had it, 21% of women and 33% of men reported that they would.

These findings contrast rather markedly with those of Wood (2002) who spent eighteen months conducting fieldwork with youth in Umtata. She found them acutely aware of HIV, mostly personally knowing people affected, often fearing that they themselves were infected but not expressing to her, or to any of her field assistants, attitudes of the nature described by Leclerc-Madlala and Myburgh or intentions to deliberately cause infection. This was not because of any reluctance to discuss sensitive issues with the research team and as, for example, first hand accounts of rape perpetration were collected. In general research on what ‘would’ be done if a person ‘were’ to find themselves to have HIV needs to be interpreted with caution as responses to hypothetical questions rarely predict actual behaviour.

8. Legal and policy framework for preventing and responding to child sexual abuse

8.1 International instruments

UN Convention on the Rights of the Child, 1979
Obligations on the State:

- to take all appropriate legislative, administrative, social and educational measures to protect the child from forms of physical and mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of the parent(s), legal guardian(s), or any other person who has the care of the child. Such protective measures should as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for other forms of identification, reporting, referral, investigation, treatment and follow up of instances of child maltreatment described in the convention;

- To protect children from all forms of sexual exploitation and sexual abuse taking all appropriate national, bilateral, and multinational measures to prevent:
  - The inducement or coercion of a child to engage in any unlawful sexual activity;
  - The exploitative use of children in prostitution or other unlawful sexual practice;
  - The exploitative use of children in pornographic performances and materials;

- To take all appropriate national, bilateral, and multinational measures to prevent the abduction or sale of or traffic in children for any purpose or in any form;

- To take all appropriate measures to promote physical and psychological recovery and social integration of a child victim of: any form of neglect, exploitation, or abuse, torture or any form of cruel, inhuman or degrading treatment or punishment; or armed conflict. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child

African Charter in the Rights and Welfare of the Child
Obligations on the State:

- to take specific legislative, administrative, social and educational measures to protect the child from forms of torture, inhuman or degrading treatment and especially physical and mental injury or abuse, neglect or maltreatment, including sexual abuse. Such protective measures include establishment of special monitoring units to provide necessary support for the child and for those who care for the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow up of instances of child abuse and neglect;

- To protect children from all forms of sexual exploitation and sexual abuse in particular taking measures to prevent:
  - The inducement, coercion or encouragement of a child to engage in any sexual activity;
  - The use of children in prostitution or other sexual practices;
  - The use of children in pornographic activities, performances and materials;

- To take appropriate measures to prevent:
  - the abduction or sale of or trafficking in children for any purpose or in any form, by any person including parents and other care-givers or legal guardians of the child;
  - the use of children in all forms of begging

- no child should be subject to arbitrary or unlawful interference with his/her privacy or attacks on his/her honour or reputation

8.2 Domestic legislation and policies: South Africa
Rape of women and children of all ages is a crime in the countries of Southern Africa. In addition to the Constitution, the South African national legislation aimed at protecting children from sexual abuse includes:
- The Child Care Act No 74 or 1983 (as amended)
- The Child Care Amended Act No 96 of 1996
- Sexual Offences Act No 23 of 1957 (as amended)
- Domestic Violence Act No 116 of 1998
- The Criminal Procedure Act No 51 of 1977
- The Multi-disciplinary Child Protection and Treatment Protocol

The Bill of Rights of the Constitution includes provisions aimed at ensuring the protection, promotion and respect of human rights of all South Africans including children. Section 10 states that ‘everyone has inherent dignity and the right to have their dignity respected and protected’. Section 12 (1) (c) guarantees the right ‘to be free from all forms of violence from either public or private sources’. Subsection (1) (e) guarantees the right not to be treated or punished in a cruel, inhuman or degrading way’. Children are specifically guaranteed the right to be protected from maltreatment, neglect, abuse or degradation.

**Draft sexual assault policy**
In South Africa the legal position is outlined in the Draft Sexual Assault Policy of the National Department Of Health as follows: Sexual crimes in South Africa are prosecuted under both common law and statutory law. The common law of South Africa is based on Roman-Dutch principles, which have been modified to a considerable extent by English law, by legislation, and by certain influences from Europe. Sexual crimes prosecuted under common law include rape, sodomy, bestiality, incest, public indecency and indecent assault, while sexual intercourse with minors is prosecuted in terms of the Sexual Offences Act (23 of 1957, as amended).

Rape as it is currently defined, consists of intentional, unlawful sexual intercourse with a female of any age without her consent. South African legal practice presumes that a girl under the age of twelve years is incapable of consenting to sexual intercourse. Sexual intercourse with a girl under 12 years is always rape and is prosecuted as such under common law. Sexual intercourse with a girl under the age of 16 years, with her consent, is illegal in terms of the Sexual Offences Act, and without her consent is common law rape.

Sodomy is defined as anal intercourse between two men. Bestiality is anal or vaginal intercourse between a man or woman and an animal. Incest is defined as sexual intercourse between two people who according to law may not marry. Public indecency consists in unlawfully, intentionally, and publicly committing an act which tends to deprave the morals of others or which outrages the public’s sense of decency and propriety. There are vast arrays of acts that constitute the offence of indecent assault, but it is defined as unlawfully and intentionally assaulting another with the object of committing an indecency.

The Sexual Offences Act creates a number of offences relating to sexual intercourse or sexually indecent acts and related conduct such as keeping a brothel and procuring women for the purposes of intercourse. The Act criminalises sexual intercourse with minors under the age of 16, prostitution and same-sex sexual acts (Martin 2001). A boy who is under the age of 7 years is irrefutably presumed to lack criminal capacity and thus cannot be charged with rape. A boy between the ages of 7 and 14 years is presumed likewise but may be convicted if the state can establish that he was aware of the crime.
It is widely recognised that the Sexual Offences Act, Act 23 of 1957, needs substantial revision and the South Africa Law Commission has been consulting on drafts of a discussion document for the last three years and draft legislation. This revision recognises people’s rights to diversity in sexual preferences but serves to protect people from coerced sexual acts. It is hoped that new sexual offences legislation will be tabled before the end of 2003.

The Child Care Act of 1983 is the main statute for the protection of children. It determines the powers of commissioners of child welfare and governs the operation of the children’s courts. It provides for the investigation of cases and placement of children in alternative care or under the supervision of social workers where necessary. Section 42 compels every dentist, medical practitioner, nurse, social worker, teacher or any person employed by or managing a children’s home or place of care or shelter, who examines, attends or deals with any child in circumstances giving rise to the suspicion that the child has been ill treated or sustained a deliberate injury to immediately notify the Welfare Department or face criminal sanction. According to section 42(3) the provincial Director General of Social Development or the designated officer shall arrange that the child and its parents receive treatment. The Prevention of Family Violence Act (1993) also provides for the reporting of suspected child abuse.

The Child Care Amendment Act criminalizes participation in or involvement with commercial sexual exploitation of children. It makes it an offence for anyone who is the owner, tenant, manager or occupier of property on which such activities occur to fail to report them to the police.

The Film and Publication Act (no 65 of 1996) protects children from sexual exploitation or degradation in publications, films or on the Internet. It makes it an offence for any person to knowingly create, produce, import, distribute or possess publications or film which contains a visual presentation and or scene of child pornography.

8.3 Domestic legislation: Swaziland

In Swaziland rape is a common law crime. The Girls’ and Women’s Protection Act no.39 of 1920 prohibits any form of sexual intercourse by any man with a girl under the age of 16 years, or any form of immoral or indecent dealing by any person with a girl of such an age. The solicitation or enticing of such a girl to commit any such acts is also made an offence. However it is a defence of the girl is a prostitute or the boy is under 16 years. The penalty is imprisonment for up to 6 years with or without lashes and with or without a fine. The Public Health Bill no 6 of 1999 makes knowingly infecting another person with HIV an offence, which obviously could pertain in some situations of rape. The Crimes Act No 6 of 1889 prohibits a parent or guardian from making a girl available for unlawful sexual intercourse with any man. It also makes it an offence for a parent or guardian to be party to or permit or receive any consideration for defilement, seduction or prostitution of a girl. Punishment is imprisonment for life with whipping if the girl is under 12 years.

8.4 Domestic legislation: Namibia

In Namibia the Combating of Rape Act, No.8 of 2000, is the main legislative instrument. This recognises rape of men and boys as well as women and girls. Rape is defined as the “intentional commission of a sexual act under coercive circumstances”. A sexual act includes the penetration of any bodily orifice by any bodily part (penis, finger, tongue) or object or part of an animal and also included genital stimulation. Coercive circumstances include force, threats of force and other circumstances where one person takes unfair advantage of another. The age of consent to sex is defined as 14 years, for boys and girls. Intercourse with children younger than this is only not rape if the perpetrator is less than 3 years older than the victim and there is no coercion. The minimum sentence for rape of a child is 15
years with a maximum of life imprisonment. The court is closed during a rape trial unless the complainant requests otherwise and the law prevents the publishing of the names of rape victims (Legal Assistance Centre 2001). The Combating Immoral Practices Amendment Act No. 7 of 2000 states that should a rapist knowingly expose his victim to HIV-infection he will receive the maximum sentence. Such behaviour also forms ground for a murder charge.

The Children’s Act No. 33 of 1966, as amended, still forms part of the law in Namibia and is a major instrument for tackling child prostitution and child sexual abuse of forms other than rape. Child law reform is currently being considered in Parliament making long awaited amendments to provisions for child care and protection. The legal system will hopefully be geared to protect the child as a vulnerable witness in a Court of Law, amongst a wide range of other important child care and protection provisions.

8.5 Domestic legislation: Botswana
Legislation in Botswana is complex as there are two systems of law in operation: customary law and general law (WLSA Botswana 1999). The latter is based on Statutory Law and Roman Dutch Law. There is no protection against child marriage in Botswana. Customary law has no prescribed marital age and since most marriages are negotiated between families, with the couple at times incidental to the process, young girls are vulnerable to forced marriages. Betrothal of children at birth to elderly men occurs and the girls are then married at puberty under customary law. Under Statutory Law a girl’s marriageable age is 14 years and a boy’s is 16.

The Penal Code (Cap 08:01 Section 147) states that a girl cannot consent to sexual intercourse until the age of 16 and a man can be charged with defilement. This contradicts the law on age at marriage. There is no crime of rape in marriage and so married children are not protected by other laws. Defilement carries a sentence of 10 years – life imprisonment but is narrowly defined in terms of penile penetration. Rape, a gender neutral crime, is outlawed in terms of section 141 of the Penal Code and attempted rape in terms of section 143. There is a further crime of indecent assault (Section 146 (2)) and there is “no defence” to a charge of indecent assault of a person under 16 years.

8.6 Domestic legislation: Lesotho
Child sexual abuse is Lesotho is currently covered by the Child Protection Act 1980. This is in the process of being reformed and there is an extensive consultative process on revisions through a Child Law Reform Project and implemented through the Lesotho Law Reform Commission and Ministry of Justice, Human Rights and Rehabilitation.
Figure seven: Roles of role players in notification of child sexual abuse in South Africa
(source: Dept of Social Development 2001)

Social Worker
* be alert to and recognise abuse
* screen cases and determine whether it’s a first referral
* assist child with disclosure
* evaluate safety of child and arrange place of safety (if necessary)
* counselling for child and family
* report to central child abuse register
* coordinate services and refer to other role players
* investigate social circumstances
* arrange case conference
* follow up on referrals to CPS team members
* prepare child for court
* prepare final Children’s Court Inquiry (CCI) report
* convey and explain outcome of court proceedings to child
* arrange after-care services
* on-going monitoring and evaluation of services for the child

South African Police
* take initial statement
* refer to the FCS
* refer to forensic social worker where appropriate
* inform and request a social worker to join investigation
* take child’s statement
* ensure child’s safety
* decide with social worker whether to proceed with a criminal case
* refer and escort child to doctor for examination and J88 completion
* visit scene of crime for evidence and exhibits
* obtain forensic evidence and send off specimens to labs
* obtain relevant statements
* trace and arrest abuser
* take abuser to court within 48 hours
* attend case conference and prepare documents
* oppose bail
* take case to court
* adjust abuser’s record if found guilty
* report to perpetrator database
* terminate case

Public Prosecutor
* avoid delays where possible
* go through docket
* examine medical report to ascertain injuries
* apply timeously for an intermediary
* interview each witness
* confer with CPS and determine charges to be laid
* organise opposition to bail. Inform victim /family of bail conditions if it is granted
* see child is not exposed to accused or his family/friends whilst awaiting trial
* work with social worker through out process
* see that justice is done

Justice
* the Clerk of the Court must notify the Director General of convictions and the outcome of the Children’s Court Inquiry if the reasons for the removal was child abuse or neglect
Health Workers
* recognise sexual abuse
* be kind and believe child
* notify social worker and CPU/FCS
* ensure confidentiality and privacy

Doctor
* explain process to child and care-giver
* obtain consent
* take full history
* undertake a full medical and forensic examination and complete J88
* treat STDs, give pregnancy prophylaxis, HIV counselling and testing and offer antiretrovirals
* arrange referral to mental health services or paediatrician
* attend court

Nurse
* receive and support child
* be present during medical examination

Psychologist
* psychological assessment
* conduct disclosure interviews
* provide psychotherapy
* supervise counsellors
* attend court

CBOs, Youth, Community workers and community structures
* support and encourage child and family involved
* help reintegrate child into society after the case
* child abuse prevention

Teachers
* identify suspected sexual abuse
* discuss with child/parents
* refer cases to social worker where child lives or police
* share any relevant information with team members
* support child
* protect child when in school
* inform all children at school who they can talk to about child abuse
8.7 Procedures in child abuse cases in South Africa

*Reporting cases*

Sexual abuse is often deliberately revealed by a child to a third party, usually a parent, guardian, teacher, friend, doctor, psychologist, relative, neighbour, social worker or priest. It can also be inadvertently revealed through the child’s behaviour or signs noticed on the child’s body. These may include symptoms of infection, genital injury, abdominal pain, constipation, chronic or recurrent urinary tract infections, or behavioural problems, including inappropriate discussion or displays of sexuality and sexual knowledge (World Health Organisation 2002). In South Africa there is a statutory framework for mandatory reporting of child abuse to a police official, Commissioner of Child Welfare or to a social worker (see above).

*Disclosure by children*

Research in the United States points to disclosure of abuse by children occurring in different stages. Whilst these do not follow a set path or timeframe for progression between stages, it can be helpful to know them to understand children’s reactions to discussion of abuse (Sorensen & Snow 1991).

**Stages of disclosure:**

*Denial:* this normally happens when a child is questioned about abuse or identified as a potential victim and pressurised to tell

*Tentative disclosure:* when the child partially acknowledges the abuse and gives vague information about it

*Active disclosure:* when the child makes a personal admission of having experienced sexual abuse

*Second denial:* may be prompted by a child’s needs to protect his or her loved ones from trauma

*Reaffirmation:* full account of the abuse

*Rights of the child with respect to the handling of the case*

Children and their parents/caregivers have the following rights and expectations of assistance in situations of child abuse:

- The best interests of the child shall be paramount
- Children have a right to express an opinion, to be involved in all decisions and to have their opinion taken seriously
- Children have the right to have their cases managed by trained professionals
- Children have the right to be present when decisions are made, except where their participation would not be in their best interests
- Children have a right to have processes explained to them in a manner in which they can understand
- The child has a right to have procedures dealt with expeditiously
- Cases are handled by the Family Violence, Child Protection and Sexual Offences Unit or a specialist member of the police where no Family Violence, Child Protection and Sexual Offences Unit is available
- The child’s statement should be taken with professionalism, care and accuracy
- It should be read back to the child or the parent/caregiver and signed by the child or the parent/caregiver
- The criminal process should be explained to the child or the parent/caregiver by the officer taking the statement, as should the rights of complainants to information on progress of the case, court process, and when the child will be called to testify.
• The case number and contact details of the investigating officer who will handle the case should be given to the child or parent/caregiver
• Every child has a right to a medical examination
• Every child has a right to treatment

**Criminal procedure which protects children**
The Criminal Procedures Act makes provision for some special measures aimed at accommodating the special needs of child witnesses. These include:

- child witnesses are guaranteed protection from disclosure of their identity, only the judgement and sentence will be given in open court, and even so the identity of the child will be protected
- the publication of the child’s identity is prohibited
- it is possible for a child witness to testify outside court. The court may appoint an intermediary to enable the child to give evidence through the intermediary – by relaying the questions to the child and the responses to the court. Normally Closed Circuit TV is used with a one way mirror in the room with the CCTV so the court can see the child but the child not see the court. Certain people can be appointed as intermediaries including health and social work professionals.

**8.8 Weaknesses in the procedures**
The South African Human Rights Commission Hearings (2002) heard evidence from a variety of staff in Gauteng about failures of the procedures in child abuse causes. These included:

- inadequate statement taking from the abused children– the police docket often contained only one statement from the child instead of the expected supplementary statements
- police stations lacked private rooms for evidence taking and were described as “sordid and victim hostile”
- police lacked skills to interview abused children
- police joked about reports of child sexual abuse and refused to open cases, especially when the child was a teenager and the situation was acquaintance rape
- police accused mothers of telling children what to say
- cases were poorly investigated and often little effort was made to locate and arrest perpetrators,
- withdrawal of cases was a very substantial problem and attributed to loss of interest in the legal process, the abuser paying compensation, fear of loss of economic support from him especially where it was a father, intimidation, lack of confidence in the system, lack of funds for travel to distant courts, and possibly in some cases the charges being unfounded.
- Some cases did not reach court as key evidence went missing or the police lost contact with the abused child and caregivers
- Poor quality police statements
- Police sometimes failed to accompany children to doctors and no feedback was given on findings from the examination. Many doctors were reluctant to see cases because of the possibility of going to court and children having long delays in accessing medical care. Doctors were not trained in examining children and the quality of examinations was often poor
- Children were often not given appropriate medical treatment after rape and no HIV preventive medication. HIV testing might be done without counselling
- Prosecutors also lacked the skills to deal with child witnesses and to interpret childrens’ responses to questions. Defence attomeys had a similar lack of skills
and magistrates and prosecutors lacked the knowledge to object to inappropriate conduct in the part of the defence attorneys

- Prosecutors often failed to safeguard the interests of the child e.g. by opposing bail and motivating for child friendly criminal procedures
- Children were inadequately prepared for court
- Multidisciplinary coordination was poor
- Social workers were too few and insufficiently experienced in handling these difficult cases. There was a lack of long term therapy for children
- Children seldom received therapy after cases despite it being assured in the Multi-Disciplinary Child Abuse Protocol

They concluded that the system does not work for sexually abused children, it is hostile and further traumatises children. They made a large number of recommendations for the substantial overhaul of each component of the system.

8.9 Factors influencing the level of violence in schools
Brookes (2001) found that lower levels of sexual violence were found in schools where there was a better understanding of sexual violence and acknowledgement of the problem. In particular having male educators who were willing publicly to address the problem and actively participate in preventing it. School policies on violence and appropriate behaviour were important but were only implemented where the guidelines identified different kinds of gender violence, stipulating the seriousness and level of sanction, procedures for dealing with cases and structures for reporting these. Clear and repeated communication of the policy and procedures to all partners – learners, parents and educators – was found to be important for policies to be effective. The general climate in the school was found to be very important in influencing levels of violence. The school with the lowest levels of violence against girls was found to have zero tolerance to any form of violent behaviour, close monitoring of learners, unified and consistent application of rules by educators and an emphasis on respect as a core social value. This school had no programmes on gender relations nor covered gender violence in its curriculum. A key finding of the research was that programmes addressing gender attitudes in schools were in themselves insufficient to address the problem of gender-based violence.

9. Research directions
9.1 Research in progress
There are a number of research projects on different aspects of child sexual abuse which are currently underway.

- USAID is funding a study which is being undertaken by the National Prosecuting Authority and collaborating partners. It is still in the planning stages but a profile of convicted child sexual abuse perpetrators is planned.
- The Human Sciences Research Council has a study entitled “Protective consequences of school and community networks for children attending primary school”. This study focuses on the school communities surrounding 12 primary schools in Gauteng and KwaZulu-Natal. It is exploring the physical space around schools through which children travel as they arrive and depart, the continuity in time of supervision of young children, the relationships between the schools educator and principal with other structures within the community, as well as the procedures and structures in place to prevent and report violence against children.
- The Human Sciences Research Council is publishing a book on child sexual abuse in South Africa which will be published in October 2003.
The Medical Research Council Gender & Health Group is undertaking research in the Eastern Cape with interviews with a non-random sample of 1400 men and 1400 women aged 17-23 years. The questionnaire includes questions on forms of trauma experienced in childhood and experiences of child sexual abuse. The analysis will explore associations between child abuse and subsequent sexual and reproductive health including HIV infection, and relationships.

9.2 Future research directions

Research on child sexual abuse in Southern Africa is very limited and the great majority of work comes from South Africa. With some notable exceptions, the research base is characterised by a preponderance of small studies which do not very greatly enhance understanding of the area. Many of the studies, both qualitative and quantitative, large and small, have important weaknesses in their conceptualisation, research design, conduct or data analysis.

Given the indicators of the magnitude of the problem of child sexual abuse, a substantial body of rigorous research is needed to shape interventions on almost every aspect of child sexual abuse. It is important that there is a considered approach to research agenda setting. A meeting convened by Human Science Research Council and supported by the Ford Foundation in August highlighted certain dangers. The tide of public concern about child sexual abuse has resulted in commissioning of several short term projects with considerable duplication. Some of the projects have been and are being designed with an emphasis on rapid results rather than following research questions and methods which may take longer but yield far more useful findings. Children have been sexually abused for many many years, the problem will not be effectively understood and tackled through short term strategies. The area requires and deserves the same level of funding, expertise and high quality research as the well established health problems facing our region. There is a need for prioritisation of operations research and improving responses to sexual abuse, however the research agenda must be comprehensive since so little is known of the magnitude and nature of the problem.

Basic research should include:

- the prevalence of different forms of sexual abuse in a range of settings, using where possible standard research tools to enable comparison of findings
- study of risk factors, both for being sexually abused child and an abuser and the broader social and cultural context in which abuse occurs
- study of the health and social consequences of different forms of child sexual abuse
- study of factors influencing recovery of health following sexual abuse

Determining effective responses to child sexual abuse

Interventions must also be studied to produce a better understanding of what is effective in different settings for preventing sexual abuse and for treating and supporting abused children. The following areas should be given priority:

- documenting and evaluating services and interventions that support abused children or work with abusers
- determining the most appropriate health sector responses to sexual abuse of children including where services should be delivered and by whom
- determining what constitutes appropriate psychological support for different settings and circumstances
• evaluating programmes aimed at preventing sexual abuse of children, including community-based interventions – particularly those focusing on men – and school-based programmes
PART TWO:

COMPARATIVE STUDY OF CHILD SEXUAL ABUSE IN NORTH WESTERN MPUMALANGA AND WINDHOEK, NAMIBIA
COMPARATIVE STUDY OF CHILD SEXUAL ABUSE IN NORTH WESTERN MPUMALANGA AND WINDHOEK, NAMIBIA

1. Introduction

The aim of this research was to add to the current body of knowledge on child sexual abuse by investigating the circumstances of child sexual abuse, community members’ perceptions of its cause and their reactions to abused children and abusers, and services for abused children in two diverse southern African settings. The researchers were particularly interested in collecting evidence of links between child sexual abuse and the HIV epidemic. The study used rapid ethnographic methods and the same scope of inquiry was used in each setting. The data however differs as different researchers worked in the two sites and there were different possibilities for access to children who were known to be abused, and their families, for interview. This part of the report presents the methods used in the two sites and discusses the findings. Details of the findings are found in the full site reports which are presented in appendix A and B. For the purpose of this study, the United Nations definition of a child is used i.e. a girl or boy under the age of 18 years. The terms ‘sexual abuse’ and ‘sexual violence’ are used interchangeably and defined as in the desk review.

2. Methods of research

Research organization and settings

The data was collected in September and October 2002. The two study sites were chosen largely for their accessibility and diversity: the South African site being in a rural area and the Namibian, being the capital city. In each site the fieldwork was organised and conducted by a different team. The fieldwork in Mpumalanga was managed by Loveday Penn-Kekana. Here most of the interviews were conducted by a young woman with a degree in anthropology, Josephine Malala, in local languages (mostly Ndebele). In Namibia, the work was lead by Hetty Rose Junius. Amanda Kruger, (Social Worker and Director of Life Line/Child Line), Rianne Selle, (Co-ordinator of the Multi-Media Campaign of the Prevention of Violence Against Women) and Father Herman Klein-Hitpass, (Roman Catholic Priest and community activist) were Specialist Consultants. Six field workers, representing a range of ethnic backgrounds, undertook interviews: Veronica Theron, Helen Mouton, Eveline January, Sannie Ockhuizen, Lucy Bock and Victoria Marenga. They were aged from teenage, to much older and used languages appropriate for their interviewees (mostly Afrikaans). Some were abused children, mothers of abused children and others were social workers or community activists.

The district in Mpumalanga was located in the north west of the province. It was selected because there was at least one NGO working in the area around the topic of child sexual abuse and child vulnerability. Three types of community could be found in the area and informants were selected from all types. The first, was a formal township, with build brick houses, water, electricity and tarred roads. Here most of the people worked for local government, or were professionals such as teachers, nurses, police officers or social workers. There was also a large informal settlement, where most of the homes were shacks, roads were not paved, and electricity had only recently been provided to some homes. Levels of unemployment were high, work available was often seasonal on nearby farms or casual work in nearby factories. Many people commuted to Gauteng for employment, either on a daily, weekly or monthly basis. The community also encompassed rural areas in the district. Here few people were actively involved in agriculture; instead they mainly relied on remittances from adults working Gauteng, or on pensions or other forms of...
grants. Many of the households consisted of grandparents looking after grandchildren while parents worked elsewhere.

Although there were a number of health facilities within the district, most cases of child sexual abuse that were reported either to the police or to local clinics were transferred across the provincial border to Gauteng where specialist services were provided. There was one main police station within the district to which all child sexual abuse cases where theoretically reported. This police station had a number of staff that dealt specifically with cases of child sexual abuse and violence against women. There were a number of CBO’s and NGO’s working in the district that were concerned with issues of child sexual abuse and were providing services for abused children and doing outreach work. A number of parents reported that issues of child sexual abuse were dealt with at schools.

In Namibia, the geographic base of the study spanned the entire capital city, which is small by South African standards, with an official population of 251,540. The city has areas of different socio-economic status from wealthy to very poor and reflects much of the ethnic diversity of Namibia. People from many different ethnic backgrounds were interviewed in this study. In Windhoek all cases of abuse of women and children are referred to one Women and Child Protection Unit which is a one-stop centre with police and social workers. Many of the people involved in the study had connections with the centre.

Informants
In Mpumalanga, data was collected by in-depth interviews and small group discussions were held with younger people. In total, 30 adults and 9 teenagers were interviewed. Staff at the specialised clinic in Gauteng were interviewed as well as those from health care centers within the district, which referred to this clinic. One doctor, who was a district surgeon, as well as four nurses and two social workers were interviewed. Two police officers, four teachers, as well as a service provider working in a crèche and facility for the disabled. Although attempts were made to interview abused children or their families it did not prove possible to do this in Mpumalanga.

In Namibia, a total of 47 people were interviewed. Fourteen interviews were undertaken with children who had been sexual abused, both boys and girls. Nine were undertaken with parents or guardians. These cases were identified from the social workers’ reports at the Windhoek Women and Child Protection Unit. They were supplemented by interviews with well-known key informants and community leaders or workers who were in some way involved with child care and protection. Sixteen key informants were interviewed: two police officers, one nurse who ran a children’s home, one social worker from the Windhoek Women and Child Protection Unit, five NGO staff (one was a social worker and Director of Lifeline/Childline), two teachers, two traditional healers, two traditional chiefs and a priest. Four men and four women from the community were also interviewed.

Service providers provided information on the type of cases seen, perceptions of links with HIV, of causes of vulnerability to children and limitations of the services. Children who had been abused provided accounts of their abuse and information on how they perceived the rules of respect to operate vis a vis adults and what they perceive to be risks attached to breaking them. Men, women and young people who were not selected for interview on the basis of any special knowledge of child sexual abuse provided information about the context of child rearing, their perceptions of child sexual abuse, and perceptions of links between child sexual abuse and HIV as well as services provided and barriers to using services. Special care was taken in interviews both in terms of the process of obtaining consent, and the nature of questions asked to ensure that abused children did not have their confidentiality breached.
Interviews
Data was recorded with tape recorders after informants had given consent. In the case where informants were prepared to be interviewed but did not consent to be tape recorded, notes were taken. Informal interviews were also conducted and recorded in the form of notes in some cases prior to the formal interviews. All tapes were transcribed and translated into English and all interview notes were written up.

Interview questions were formed around the appropriate parts of the scope of enquiry. Informants were asked about the types of sexual assault cases they were familiar with, social rules governing adult child relations in the community, ideas about child care and supervision, responses to abused children and the abusers, ideas about how child abuse could be prevented, barriers to seeking services after abuse and problems with services for children who have been sexual abused. Questions were open ended and differed between different groups of participants. All responses were followed up with probing where appropriate so as to enable the researcher to further explore issues that were raised in interviews.

In Namibia, some three focus groups were held with children. They were asked to do activities that would enable them to explain their relationship with adults and their perceptions of adults’ expectations of them. They were asked to draw pictures and make models from clay of people they liked and people they did not like and to explain the meanings of their drawings as well as to describe what they liked and what they didn’t like about those people. The discussion was tape recorded and the children were asked if we could keep and use the pictures.

Analysis of the Data
When all the interviews had been transcribed, the interviews from Mpumalanga were independently coded by the three researchers involved in the research project. The scope of enquiry outlined in the research proposal guided the data analysis. The report was written by Loveday Penn-Kekana with Rachel Jewkes. The data from Namibia was coded by Rachel Jewkes who wrote the report in consultation with Hettie Rose-Junius.

Challenges in Analysing the Data
The experienced researchers working on this study perceived that there were challenges in analysing the data which were more sharply focused by the topic of research than is commonly the case. This was most apparent in the data from Mpumalanga because so few of the informants had first hand experience. These meant that data analysis had to be approached with great caution. One of the problems was that the topic was one which generated very strong emotions in the interviewees, as it has generated strong views in all sections of our society, but many of them did not have first hand knowledge or experience of cases or of many cases. It was notable that whilst many people made strong statements of ‘fact’, especially in relation to causes of the problem, probing revealed that they often could not back up these statements with evidence. For example service providers in Mpumalanga would state that the ‘virgin cleansing myth’ was definitely an explanation for child sexual abuse. But when asked about cases that they themselves had dealt with or heard of there would not be one case of child sexual abuse resulting from this that they could mention. Instead they would provide other explanations, and suggestions of causation.

There were also a number of interviews where informants, when initially asked about a question, gave one set of answers, and then when the matter was probed later in the interview would give a contradictory account of the same incident. Although it is often the case in qualitative research that people express views that lack internal coherence, this was
particularly noticeable in many of the interviews in this project conducted with people with little personal experience of child sexual abuse. This may be a reflection of the bewilderment of many people about why people do sexually abuse children.

The impact of the national media of people’s perceptions of issues around child sexual abuse also became apparent in careful analysis of the data. Informants would be asked if they perceived child sexual abuse to be a problem in their communities. They would say that it was, and then refer to the national media and stories about abuse in other parts of the country as proof that this was the case. While the fieldwork for this study was being carried out the case of the baby rape in Northern Cape was receiving a large amount of attention. In a number of the interviews in this study this case was often given as proof of occurrences of events or causation of events that happened in the area of Mpumalanga that was being studied.

What also emerged from the data in Mpumalanga was that there were certain ways of talking about child sexual abuse, and certain ideas and incidents that had gained an almost ‘urban legend’ status in the district. Certain stories, which were almost identical, were told again and again. It became difficult sometimes to ascertain with certainty whether people were talking about a number of different cases which were remarkably similar, or whether several people were extrapolating from one case, which had become slightly distorted in its repeated telling. Because of the very nature of child sexual abuse, and the fact that it is something that is often disturbing to people, it seems likely that in some cases that single incidents are often remembered and repeated.

Care was therefore taken when analysing the data to ensure that these concerns were addressed, and that the research findings did not extrapolate from one or two cases that had stuck in the memory and imagination of informants interviewed in this study.

*Ethical Issues*

In designing the study the researchers used the WHO Guidelines for Ethical Research on Violence Against Women, as well as discussions with other researchers who had done extensive work with children around child sexual abuse, to guide them. Before starting the study in Mpumalanga a clear understanding of the Child Protection Act and its implications in terms of legal obligation of the researchers involved in the study was obtained. Ethics approval for the study was obtained from the University of the Witwatersrand Ethics Committee. This committee raised concerns about ensuring the confidentiality of abused children, avoiding secondary victimisation and having referral systems in place if a current case of child sexual abuse was disclosed to the researcher. All of these concerns were addressed both in the design and implementation of this study. Although all sensitive to the issues of child sexual abuse, the researchers in Mpumalanga had not received training in counseling children were sexually abused. They were aware of the boundaries of their role as interviewers, and referral networks for adults or children who were sexually abused were established before the fieldwork was initiated.

In Namibia, ethical approval was sought from the ethics committee of the Ministry of Health and Social Services. All informants were told that participation should be voluntary, they did not have to agree to be interviewed and that if they declined they would not be adversely affected. Verbal informed consent to be interviewed was sought as this was deemed least intrusive. All children were approached after agreement of their parents.

Interviews with children who had been abused and their parents had to be approached with great sensitivity to avoid retraumatising the children. These interviews were conducted by trained social workers who were particularly interested in child sexual abuse. Two worked at
the time for the Women and Child Protection Unit and two had been previous employees of the Unit. They were therefore very familiar with the field, and what is and is not appropriate when approaching and talking with abused children and their families. Meetings were held regularly by research team members and in these support of interviewees was one of the main subjects discussed and all interviewers reported how they discussed each case and any issues arising, especially when more time had passed since the events discussed. All interviewers were told to refer signs of trauma to social workers currently employed by the Women and Child Protection Unit, although they also at times stepping out of the interviewer role after interviews to provide support. The lead researcher in Namibia, who was herself a former social worker with a particular interest in the area, was satisfied that no one was unduly traumatised by the interviews and that all necessary support was provided. Some of the parents and children said they welcomed the opportunity to see a person again to whom they could talk and relate how they had managed to work through the trauma.

3. Discussion of findings

Everyone interviewed in both sites perceived that the sexual abuse of children, particularly girls, was a matter of great concern in their community. This widespread acknowledgement of the problem and perception of its prevalence clearly highlighted the relevance of the research and the progress which has been made from previous periods when it was widely denied.

The research provided insights into the social context of child sexual abuse, the way that it is talked about and acted on in the two communities, and the way that services for sexually abused children and their families are perceived by both community members and service providers. What is presented includes community explanations for why adults abuse children and researchers’ interpretation of the data highlighting key themes which may be important in understanding some people’s motivations for abuse, this should not be interpreted as the motivations for child sexual abuse as study was not designed to explore these.

In neither site was there access to a random sample of cases, but the case series described in Windhoek and the cases described by informants in Mpumalanga highlights some of the key features of child sexual abuse. The most obvious feature of the cases was their diversity. Whilst child rape or child sexual abuse is often discussed as one category, it includes a very wide range of different acts against children of different ages. These may be single occurrences or repeated, they occur in different settings, with different vulnerability factors and the abused children have different relationships to the abuser. Indeed these acts are so diverse that the only obvious common ground between all of them is really that they involve children, coercion and sex. Clearly such varied acts could not have one single cause.

In the Namibian series of cases, most of the abusers were men known to the child, very often family members and quite often the abuse occurred on many occasions over a long period of time. The cases were mainly accessed through formal services and as a result those forms of sexual abuse which are rarely reported to such services, such as date rape and sexual harassment, were under-reflected in the study. The only acts which involved boyfriends which were discussed were the “tournaments” acts of gang rape organised by a boyfriend with his friends.

What was perceived to constitute child sexual abuse

The researchers in this study proceeded on the basis of international definitions of child sexual abuse. Whilst it was said to be a grave problem, what was actually considered by
community members to be child sexual abuse often differed quite substantially from such definitions. This was most visible in Mpumalanga, where discussions tended to be more general than in Namibia. Several acts which the researchers would have defined as abusive according to international definitions were not perceived as such by community members. These included the local practice of taking “snuff”, young teenage girls having very much older partners, most rape of teenage girls especially, but not only, date rape, and the abuse of boys by older women.

The practice of ‘taking snuff’ was described as happening when adults playfully touched at the private parts of young children. It was regarded as somewhat if a joke. Those interviewed who mentioned the practice, as well as one of the researchers in the project, had experienced it as a child and felt it was harmless. None of the informants made connections between this practice and child sexual abuse or child sexual abuse prevention messages. That it ran counter to the messages which children were taught in school was evident to the researchers although the implications of this are not clear. It remains a matter of speculation whether ‘taking snuff’ is linked at all by children to ideas about ‘good’ and ‘bad’ touches or what the implications of it being classified as a ‘good’ touch might be for the use of such messages in child sexual abuse prevention.

The abuse of teenage girls was much more contentious. Teenage girls clearly regarded coerced sexual experiences as abuse but many people interviewed, including some non-abused teenagers, did not classify these as such. Relationships with much older men were not considered to be abusive. It seemed that at some time around puberty, girl children were perceived to switch to being seen as people who know what they are doing, engage in sexual relationships for pleasure or for what they can get out of it, undermine or victimise adult women, have power over adult men, and are not damaged by these sexual relationships. In contrast, other research projects looking at teenage girls relationships have shown that they often experience forced initiation, coercion in the relationships, have little power when dating older men and this has long term negative effects on both their physical and mental health and it greatly increases the chance that they will be infected with HIV/AIDS (Jewkes, Levin, Nduna et al 2003). Popular ideas which accord teenage girls so much agency in relationships ignore the realities of gender power inequalities and undermine efforts to reduce child sexual abuse.

Although there were a couple of cases reported of child sexual abuse of boys, the general consensus among those interviewed was that girls were at more risk, and parents reported that they worried about their girls but not really about their boys. The abuse of boys was much more visible in Windhoek than in Mpumalanga, reflecting the fact that cases of boys were deliberately identified in Namibia and followed by the researchers. Other studies have shown that boys are at risk of abuse by women as well as men (Jewkes, Levin Nduna et al 2003), but the sexual abuse of boys has not received sufficient attention both in the media and in popular discourse. It may to some degree reflect the highly gendered nature of South African society that it is harder to recognise and acknowledge the vulnerability of boys or that women can be sexual predators. More research is needed with a specific focus on sexual abuse of boys.

Causes, motivations and context of abuse
It is clearly implausible that the diverse group of acts described in this research could have one underlying cause. Whilst it is not possible to explore motivations without interviews with abusers, it was apparent that multiple factors played a role in these incidents, in motivating the abuse, providing opportunity for it and acting as a barrier to children speaking out earlier about the abuse or revealing it before penetration occurred.
In Mpumalanga, because first hand descriptions of abuse were not available, the data constituted a range of perceptions of motivations and salient aspects of circumstances of abuse in cases which had become part of community folklore. At a loss to be able to say what makes an adult break the universal taboo of having sex with a small child, people often appear to revert to a sort of shopping list of societal ills. Many of the causes that were discussed, may reflect general problems that exist in our communities – for example deep distrust between women and men – and the widespread economic dependence of women on men – as much as child sexual abuse. It seemed at times that sexual abuse almost becoming a metaphor for what is wrong with our communities.

The most striking feature of the reports of child sexual abuse mentioned in Mpumalanga was the virtual normality of the circumstances that led to the abuse. There were no accounts of organised groups of paedophiles kidnapping children from the street – but instead it was fathers raping children because the mother was away, step-parents raping step children because the opportunity arose, uncles raping nieces because they couldn’t get girlfriends. In many cases the abuse did not seem to have happened because the abuser was attracted to children in the classic sense, but just because at that moment they were not able to have sex with a consenting adult. It was also somewhat depressing that some women in relationships said they felt that they could trust their partners not to abuse their children. One of the teenage informants, in a sad indictment of relationships between males and females in a family, said in a matter of fact way that she could not trust her own brother or father not to rape her if she wore tight trousers at home. Similarly the fact that some men suggested that an explanation for the perceived escalation of child sexual abuse was that men wanted to try something different, or that it had become a fashionable crime, indicates the low opinion that some men have about other men’s sense of responsibility.

Did rules of respect contribute to vulnerability?

In both South Africa and Namibia parent child relations are hierarchically organised and governed by rules of ‘respect’ which are similar in spirit, although there are differences in the extent of the rules and practices of their enactment amongst different ethnic and regional groups. The question of whether these rules contributed to vulnerability was most explored in the data from Namibia but the broad principles also applied in Mpumalanga.

In Namibia it was apparent from cases described that the rules of respect which governed parent child relationships provided space for sexual abuse both directly and indirectly. A direct example, which was mentioned in both sites, was of a child who was sent to the shop to buy something by her teacher shortly before the end of the school day and returned after the other children had left. She was sweet-talked and molested by her teacher. The rules of respect precluded her from refusing the errand, particularly as it was a teacher who asked. Some parents were said to warn their children against some adults, and indicated that in some situations a child could refuse an adult’s request if they perceived danger.

In narratives of girls being raped by their fathers, male teachers and uncles, all of whom would have been highly respected, the direct rules of respect did not account for the girls vulnerability. The men were not able to control the girls or rely on their silence through this mechanism and instead resorted to threats, sometimes of death or harm to others, to secure their cooperation. One father used bribes of money and gifts and gave more attention to the abused girl than the other children.

The indirect impact of ‘respect’ on vulnerability was probably greater. The distance between adults and children generated by the hierarchical and unidirectional rules of ‘respect’ reduced the ability of some children to tell adults about abuse they were experiencing, which
prolonged exposure to risk. Perhaps most important of all, the hierarchically organised rules of respect actually do not provide space for adults to respect children, particularly girl children. It is probably this aspect of the social organisation of adult child relationships which renders children, particularly girl children, vulnerable more than expected obedience of children to adults.

The rules of respect reduced the space for communication on all matters between the generations and many of the girls and boys found their parents strict, disciplinarian and they were often beaten. This made it very difficult for them to talk about sensitive issues such as sex and their risk of sexual violence. It also made it hard for children to report experiences which they encountered. One consequence of this was that adults did not seem to know where children were and what was happening to them for large period of time in the day. There was a strong perception from many of the interviewees from both sites that supervision of children was inadequate and this made them vulnerable to abuse. Whilst they particularly blamed absent or drunk parents, it seems likely that this lack of communication meant that a much wider group of parents were probably unaware of much of the daily lives of their children.

Gender hierarchy
Child sexual abuse is clearly a gendered crime. Whilst both sexes may be abused, and it is likely that abuse of boys is even more concealed than that of girls, the wealth of evidence points to the fact that girls are abused more (see the desk review and e.g. Jewkes, Levin, Nduna et al 2003) and that the sexual abuse of girls is a product of their lower position in the gender hierarchy.

Links were powerfully made by informants between the position of men in the home and community and the sexual abuse of children. The cases described from Namibia indicated that incest often occurred in the context of homes with a firm gender hierarchy and the father as the head of the household. In several of the cases, domestic violence and physical abuse of the children were both described. In one case the rape of the daughter was apparently a punishment from her father. There was also some indication that some of the fathers regarded the females in their home as subject to their control and that they were entitled to meet their sexual needs with their daughters if their wives refused them. This could have also served to punish their wives for refusing sex.

Many people in Namibia spoke of male sexual desire for children as ‘normal’. Traditionally this was reflected in marriages to girls shortly after puberty. In the modern day, the observation that some men feel it is quite reasonable to have sex with a child if his wife is not available, or she agrees and he pays her is inescapable. Whilst many people expressed horror at the idea of adult men having sex with children, given the prevalence in particular of Sugar Daddy relationships between older men and young teenagers, it is apparent that this view is not shared uniformly across communities.

Whilst most people would deny that society, communities and families permitted sexual abuse of children, the fact that it was not automatically seen by all as a good reason for a woman to leave her husband, a neighbour to report to the police, a teacher to override a parent’s views or a police man to take a suspect into custody is indicative of more general ambivalence about the nature of the offence and its seriousness. The study findings strongly suggest that prevention of child sexual abuse will be linked to improvements in the position of women and girls and the struggle for the recognition of women’s rights.
The Role of Poverty

In the interviews in Mpumalanga, people suggested that poverty interacted with child sexual abuse in a number of ways. First, and this was suggested only by a very few of those interviewed, there was a possible explanation that poor or unemployed men were not able to get adult girlfriends, and therefore would turn to children for sexual gratification.

A second way that poverty was seen to interact with child sexual abuse was that it was perceived as being a major explanation of why some mothers or other guardians did not report cases of child sexual abuse. It was a widely held belief that many women did not report their husbands because they were worried about who would provide for the family if the husband went to jail, or if he was angry at the wife. One service provider recounted a story of a woman who regretted the fact that she had reported her husband as she was now struggling to support her children.

There was the suggestion by some that children were made vulnerable to men by poverty as children who were poor and hungry would be tempted to agree to anything. Similarly mothers may turn a blind eye to child sexual abuse if it meant that they now had food on the table. Others however felt that sometimes children and mothers were bribed not with essentials for survival but ‘luxuries’ such as sweets, jeans and cellphones.

Finally it was suggested by some of those in the community that the lack of employment opportunities, and the resulting poverty in the community, was the reason that a number of mothers left their children with relatives and went to Pretoria to search for employment or to work. The fact that they were not at home and with their children, and that children were left with other people to be cared for, or left alone, was seen as creating an opportunity for those who wanted to sexually abuse children.

Whilst the factors discussed here were the most important dynamics which underlay cases of child sexual abuse, there were others mentioned. One was a belief that men who became sexually aroused needed a sexual outlet. There were mixed views on whether sexually aroused men could control themselves, but most people in Namibia who discussed this felt that they should. That some men didn’t, or that in this context children (even one’s own) were not out of bounds, was apparently a factor in some cases. Part of the explanation for loss of control was alcohol use, and there was a widely held view that people “do not think” when they are drinking. Alcohol was blamed for much child abuse and was also the vehicle for drugging some of the children who were raped in Namibia.

Community reactions

Although assertions were made that child sexual abusers were abhorred, the data from Namibia suggested that this applies to certain type of sexual abuse and not others. There was unanimity that there was no sympathy for child rapists, although the age of the children involved was not clear. In some situations in both settings, particularly abuse of teenage girls, the degree of blame of the girls themselves seemed to be greater than that experienced by the rapist. This ambiguity about who exactly is to blame for child rape has a major impact on responses after rape, decisions around reporting and pursuing cases, the post-rape experiences of abused children and ultimately rape prevention. Quite substantial stigma was described (and feared) amongst Namibian girls who had been raped, reinforcing the idea that they were indelibly ‘damaged’ by the experience and even harmful to their peers.

The interviews indicated that in Namibia communities, families and friends of the men involved often did not hold it against the man, they were even able to describe him as “good” and “not guilty” when they knew he had raped a girl (even his daughter) and it was clear that
the harm or potential harm suffered by a man through a case being reported to the police, the arrest and court case (perhaps jail) was regarded as worse than his crime.

Clearly a boy growing up in Namibia could not take a message from such community and family action that rape was unequivocally wrong. It is not really surprising that most people indicated that they did not discuss rape with their sons and indeed it had never occurred to them to do so. This is despite a recognition that rape was a major problem in society, mostly perpetrated by men and a major threat for daughters. Although we were told that boys were taught about being men, this advice from other men did not seem to include controlling their sexuality, as much as expressing it. It also reinforced the hierarchical gender relations and apparently created an ambiguity around the position of mothers and sons as gender and age hierarchies intersected. The data suggested that for this reason mothers found it very difficult to talk with sons about sex and their sexual behaviour and in particular discuss to perpetration with them. Although general difficulties in intergenerational communication also meant that girls were not given much information.

**Reporting Child Sexual Abuse**

The interviews suggested that reporting cases of child sexual abuse was possible in both settings. People were aware of the problem. Almost all of those interviewed recognised that it was appropriate to report child sexual abuse to the police, although some had ambiguous views on this. The local police station in Mpumalanga had two specially trained police officers. A relationship between the health sector and the police was also clearly working. Health care workers reported that a system was in place to ensure that children were referred for a professional medical examination by a district surgeon. Some health care workers had received training. PEP was now available in the referral clinic and service providers felt that in most cases adequate transport was provided by the police to the district surgeon.

In the community in Mpumalanga as well as awareness of the issue, there were also signs of action. Service providers reported that neighbours or other community members sometimes brought children along to services because they were worried about them. There were NGO’s and CBO’s working in the community trying to raise awareness of the problem and to provide services.

However, many barriers to reporting child sexual abuse remained. Both service providers and community members identified what they felt were potential barriers to reporting child sexual abuse. These included fear of shame or judgement both in the family and in the community, fear of poverty, the limited number of sites that dealt with child sexual abuse, lack of faith in both the police and justice system, fear of the abusers, and judgements about who were ‘real victims’ and who were not.

To improve services, and to decrease barriers, more education of community and service providers is needed. This should seek to broaden local definitions about what is child sexual abuse, and in the case of service providers, broaden understanding of their legal obligation under the Child Care Act. The main source of information on sexual abuse for interviewees was the media, which inadequately addressed issues of the broader definition of child sexual abuse as shocking headlines have been valued over information giving. Some of the children were taught about abuse at school but these campaigns seemed to have sewn considerable confusion. There was a suggestion, although it was not possible to know how far it was taken in practice, that these might damage relationships both between women and their partners, and children and their fathers by spreading ideas that no men could be trusted and that kisses and hugs from fathers could be dangerous. Several informants mentioned these concerns.
The study demonstrated that people in the community in Mpumalanga, who for the most part had not tried to access sexual abuse services themselves, perceived that doing so would be difficult. In particular they felt they would be unlikely to get satisfaction from reporting cases to the police even if they perceived this as the right thing to do. Given the extremely low rate of convictions in sexual abuse cases nationally their view is probably quite reasonable. It seems inevitable that prevention of child sexual abuse should encompass increasing the likelihood that effective action, whether punitive or rehabilitative, will be taken against abusers. This will require training, increasing personnel dedicated to these cases within SAPS and more effective functioning of the courts and legal system. It would also require the provision of resources and development of skills in working to rehabilitate men who abuse children.

In both settings there was much discussion of traditional means of dealing with men who abuse children. There was a strong suggestion that communities wanted action, but that in some cases traditional avenues met some needs that court cases did not. They were less socially destructive and may give immediate satisfaction to the abused child in terms of her part of the fine – although it was not clear how much of this she would have seen herself. However some traditional mechanisms such as marrying the girl off to her rapist would have been exceptionally traumatic. In Mpumalanga people all said the system of fines was ineffective and not used anymore but a sense of some ambiguity about the role of police and courts remained as so few people actually got satisfaction, or even protection, out of pressing charges.

The researchers in Namibia were able to explore barriers which had pertained in the actual cases they documented. The findings suggest that children are often frightened to tell adults when they have been abused. With good reason, they feared accusations of lying, blame and verbally and physically violent reactions (including death threats) to themselves and others. Perhaps more difficult to understand was a lingering fear of harming someone they loved – even if he had abused them, and guilt arising from feeling that they should have spoken out earlier or even because they enjoyed some aspects of the abusive situation such as the attention, gifts or compliments. They also feared the trauma of reporting through the courts, particularly in the well recognised situation that many of the abusers would get bail or acquitted. Although Windhoek appears to have a well functioning Woman and Child Protection Unit, which the service users mostly spoke of very appreciatively, these were still realistic fears. It was clear in the interviews that reporting to the police was only regarded as one avenue of response to sexual abuse and that keeping quiet and dealing with the matter within families and the community, particularly with payment of compensation, were two others. Whilst many people perceived that reporting to the police was appropriate, it was recognised as less likely to result in resolution of the case and there were considerable risks involved to body, finances and reputation.

Whilst Windhoek was clearly fortunate in having one service for sexual abuse for the city which many people seemed to know how to access, it was apparent that it was far from perfect. Views of users ranged from highly appreciative to very negative in terms of support and efficiency of dealing with cases. There were complaints that the service needed more resources, staff needed more training and the service was still not ideally constituted to manage the problems of working in a city with a large number of languages. This contributed to the Unit being perceived by staff as insufficiently child friendly. The Unit appears to be for the most part orientated towards facilitating the apprehension of the abuser. The needs of the abused child are only really addressed in this context. There were insufficient counsellors and no therapy for abused children in the public sector. This was very much also the case in Mpumalanga. There was a complaint that many of the staff did not particularly
want to work there and that the service was not a political priority, and thus financially not high on the agenda for development. Court cases were described as often taking a very long time which is very stressful for all concerned.

The role of teachers deserves highlighting in particular. There were several cases in Namibia of children who were abused by teachers. This clearly represents an abuse of power. Cases of schools being slow to respond were discussed and it is particularly worrying that teachers could have been kept in the classroom after complaints of rape had been made to the police. In one case the principal indicated that the complaint should have been brought to him before it went to the police, with a clear implication that he might then have tried to prevent a legal case. On the other hand, teachers were the most commonly cited people to which abused children disclosed. This is a very important position and teachers in both settings need to have information and preparation to be able to appropriately respond in this situation. Schools education programmes run by Childline were discussed as being successful in Namibia and clearly there are opportunities for prevention and case detection in schools which would benefit from greater resources.

Possible links between CSA and HIV/AIDS

One of the preoccupations around the commissioning of this study was concern about links between child sexual abuse and HIV and in particular the rumours that HIV cure seeking was fuelling the perceived rise in child sexual abuse cases in communities. This research provided no evidence to support these concerns. Whilst recognising that many cases of child sexual abuse are unreported to the police, there is no evidence in Windhoek from those which are reported that numbers of cases have increased in the most recent years. This is despite the considerable increase in public attention given to child sexual abuse in this period.

Although all adults and older teenagers interviewed in both sites were familiar with the virgin cleansing myth, none said they believed it. In Mpumalanga, in particular, almost everyone interviewed when asked about it spontaneous said they knew HIV to be incurable. In Namibia, we were able to interview the key service providers who had provided the child sexual abuse services to Windhoek over many years or had oversight of the service providers and cases over that period. It is reassuring that they were only able to recall one case which was clearly motivated by HIV cure seeking. This confirms that this is a problem in Namibia but suggests that it accounts for a very small part of the overall problem of child sexual abuse and should not be addressed as the major thrust in child sexual abuse prevention, as some have suggested.

4. Conclusions & recommendations

The research for this study was undertaken in two locations in southern Africa separated by many hundreds of kilometres and a national boundary, but the findings from each site and the slightly different focus of inquiry in each site are resonant of each other. Whilst there are differences in some of the practices, the central underlying themes around which parent, child, male and female relationships are organised, in particular the ideas of respect and gender hierarchy, are sufficiently similar for the conclusions from one site to be highly relevant for that of the other. Similarly other important influences on social lives such as poverty and restricted economic independence for women are similar in both settings. The term child sexual abuse encompasses a diverse set of acts perpetrated in diverse contexts by people with diverse relationships to the children. Clearly it has multiple causes and occurs in multiple context of vulnerability.
The research has shown that there is a need for considerably more awareness raising in communities, schools and amongst health care workers at in primary health care about child sexual abuse. This needs to address the question of what is child sexual abuse, what are the possible signs of it, what is an appropriate response from people in different positions in a community, including mandatory reporting. Since the research in Mpumalanga revealed considerable uncertainty amongst some school teachers about how to handle physical abuse and neglect, and since different forms often co-exist, it may be advisable for awareness raising to focus on all forms of child abuse.

Raising awareness about child abuse with children is clearly important, especially in case identification, but the study has suggested that some approaches may be counterproductive. Messages and approaches to work on child sexual abuse in schools need to be evaluated to ensure that they do equip children with information which can improve their safety and they do not result in unacceptable confusion. Clearly schools need to increase efforts to take effective action against teachers who abuse their positions as otherwise all work on this issue in school is undermined.

Whilst child sexual abuse is widely perceived as a problem, the response of society overall to it is ambiguous. Children who have been abused are often blamed and experience lasting stigma or disruption of their lives, whilst abusers are often supported by their spouses, family, friends and the community at large, especially when the child involved is older. Fear of being blamed was a powerful barrier to disclosure of abuse for children. Society needs to clarify its priorities and messages. Raising awareness of the full scope of child sexual abuse and shifting community definitions of childhood is one part of this, improving the responsiveness of services and schools to all children who are sexually abused including teenagers is also important.

A very substantial group of men who sexually abuse children are men who take very much younger girlfriends, often in sugar daddy relationships. These men place the girls at grave risk of HIV, but have been largely ignored by researchers and almost totally ignored by interventions. Key priority should be given to research on and the development and roll out of interventions to change public perceptions of sugar daddy relationships. This will both reduce child sexual abuse and reduce the very high levels of HIV infection amongst teenage girls.

Efforts to alleviate poverty are very important in combating child sexual abuse. The lack of economic alternatives places children at risk when parents travel to seek work and leave them alone or leave them unsupervised for very long periods in the day. Community initiatives for caring for vulnerable children have tended to focus on very young children, developing appropriate responses and options for older children is very important.

Poverty alleviation is also important in reducing the attraction of transactional sex to teenage girls and protecting children from being prostituted by caregivers. Poverty also very sharply reduces the options for mothers who learn that their husband or partner is abusing their children. As well as rehabilitation of abusers, increasing women’s economic independence will greatly increase women’s ability to leave abusing men and protect their families.

The research also suggests that the use of violence in parenting practices and strict hierarchy between adults and children place children at risk and act as barriers to disclosure of abuse. Improvements in communication between adults and children are essential if parents are to understand more about children’s lives and offer advice on protection against danger and to hear early of problems which may be occurring. Parents do not need skills to communicate in these ways with their children, rather what is required is a substantial
rethinking of parenting practices which involve changes in certain aspects of hierarchical relations. Parenting has changed quite substantially in South Africa over the last few decades, largely necessitated by social changes, the results of this research suggest that further changes are required. This is not to advocate an end of ‘respect’ between adults and children but modifications to improve communication.

In both Mpumalanga there were basic services for sexually abuse children. In Windhoek, these were greatly assisted by having a dedicated Unit. To a certain extent this was clearly a working model and appropriate to a city of modest size and geographical base. In Mpumalanga the services were much more disparate. The most obvious weakness of both services was the lack of focus on serving the needs of the abused children. In neither setting was there counselling and treatment for abused children to help them over the immediate trauma or to mitigate the long term consequences of child sexual abuse on child victims. These need to be introduced as a matter of priority.

Even in Windhoek's one stop centre, medical services were not incorporated. Specialist medical services are important for children who have been abused and research evidence points to the very much better assessment and treatment provided by specialists in child sexual abuse rather than generalists. Training specialist medical staff to assess such cases and deploying them nationally is a priority.

Both services were more orientated towards the criminal justice system, yet this in itself was performing inadequately as cases took a long time to be heard and convictions are very often not achieved. Processes for investigation of cases and hearing of cases in court need to take into account the vulnerability of children and special training is needed for all staff involved in these cases.

In both settings there was no rehabilitation for perpetrators whether in conjunction with legal cases or, in appropriate cases, as a substitute for these. In a low socio-economic setting where many mothers are reluctant to pursue cases because they need the abuser’s income, the development of rehabilitation which can keep families intact but have abuse stop are essential and need to be developed by the Government and offered for suitable cases.

This research has shed light on some of the reasons why our societies have found it so difficult to come to grips with child sexual abuse. It suggests that children are rendered vulnerable to abuse but many aspects of the enactment of many of the central organising tenants of our society. Prevention of child sexual abuse requires radical change to many of the great social privileges – the status of men and the status of elders. In most cases these are changes which have already begun to occur, and social revolution is not needed to dramatically reduce levels of child sexual abuse, but it provides some of the explanation why it has been so much easier to look for scapegoats in the form of people with HIV seeking cures rather than addressing head on these major social forces.

Recommendations
For the Government:
1. Child sexual abuse needs to be seen as a priority crime.
2. All Government Departments involved in preventing and responding to child sexual abuse need to prioritise the development and introduction of effective policy and implementation strategies which protect children and facilitate the punishment of offenders.
3. Government services should be resourced to a level which reflects the severity of the crime.
4. Services need to prioritise protecting the abused children with attention given to providing a child-friendly interview, examination and court processes.

5. Training on the special needs of children should be provided to staff at all levels who work with child sexual abuse victims.

6. Rehabilitation of offenders should be more widely developed and made available nationally whether as an adjunct to court proceedings and prison sentences or an alternative.

7. Government strategies to address alcohol abuse and reduce poverty need to be seen as having a role in overall efforts to prevent child sexual abuse.

8. Government strategies to promote gender equity and enhance the status of women and girl children should be supported as essential parts of child sexual abuse prevention.

9. Research and interventions to reduce the extent to sugar daddy relationships need to be supported and promoted as part of HIV intervention and child sexual abuse reduction programmes.

Department of Health

1. The Department of Health needs to ensure that post-graduate training for health care providers both nurses and doctors is prioritised to improve sexual assault services.

2. Health services for children who have been sexually assaulted should be regarded as a specialist service and not a service provided at primary health care level where staff are already overloaded and providers would only see a few cases.

3. Health services for children who have been sexually assaulted need to be holistic providing both physical and mental support and psychological treatment, and not merely focused on the process of collecting medical evidence.

4. All health care workers need to be made aware of their legal obligations under the Child Care Act and the fact that medical evidence is not legally essential for a successful prosecution.

5. Health services should build understanding of HIV, risks associated with rape, the availability of antiretroviral therapy for people who have been raped and address the virgin cleansing myth in this context.

Department of Social Welfare

1. Further rollout of social grants to those who are eligible to reduce levels of poverty.

2. Review of the way that social workers manage their registers of children who have been victims of child sexual abuse to ensure that cases are followed up.

3. Ensuring that sufficient funds, supervision and priority is given to the area to ensure that social workers are able to do this.

For schools:

1. Educational programmes which address child sexual abuse need to be supported and evaluated to ensure they are effective and do not compound confusion on this matter.

2. Effective programmes need to be provided for primary school children.

3. Programmes need to focus on different issues with different age groups but should include discussion of transactional sex, date rape and sexual harassment.

4. Programmes in schools need to address the vulnerability of boys to abuse and the issue of boys and men as abusers of abuse.

5. All schools should have safe pathways for reporting teachers who are sexually exploiting children and clear policies forbidding teacher/learner sexual relationships.
under any circumstances, these need to be supported by effective disciplinary structures which act swiftly and remove teachers from the classroom after accusations of sexual abuse of learners

6. All schools should have teachers who have been trained in responding to disclosure of abuse and who children are informed about

**Education for children in schools, provided by NGOs or in health services should include the following messages:**

a) The scope of child sexual abuse — including in the teenage years
b) Children are not to blame for sexual abuse
c) Children should tell an adult if they experience abuse
d) Children are important and valued and none should have to experience abuse of any form
e) Signs of child abuse which a child may notice in friends or an adult may look for
f) Information about who they can disclose abuse to who will support them in schools and in the community
g) Children should not accept anyone touching their genitals, breasts or buttocks or thighs or doing or saying anything sexual which makes them feel uncomfortable
h) Forcing sex or sexual experiences of any kind on children is wrong including date rape and sexual harassment
i) Some professionals have an obligation to report certain types of cases

**Community groups and NGOs:**

1. Debate need to be engendered amongst parents on effective parenting strategies which enable parents to achieve the respect of children without the barriers to communication created by extreme strictness and discipline
2. Parents need support to build communication with children on all matters, not just on sexual matters
3. Need to develop strategies for identifying vulnerable teenagers and supporting older children who are alone for long periods of time
4. Help parents become aware of the risks to their children when they are not supervising them
5. Build understanding of HIV, risks associated with rape, the availability of antiretroviral therapy for people who have been raped and address the virgin cleansing myth in this context
6. Research and interventions to reduce the extent to sugar daddy relationships need to be supported and promoted as part of HIV intervention and child sexual abuse reduction programmes
References for part I and II


APPENDIX C
Annotated bibliography of research related to child sexual abuse as of December 2002

This paper describes a case series of cases seen over 10 years at the Red Cross Hospital after sexual abuse.

Methods: three focus groups with young men in North and Central Namibia
Findings: Masculinity amongst youth was constructed around notions of being in charge or control with unquestioned authority and dominance. Violence was used to assert control over women and described as a reaction to finding a woman with a condom because of suspected infidelity

Comparative case studies of eight schools, one primary and one high school in four communities in Gauteng, the Cape Flats and rural KwaZulu Natal. The report discusses forms of violence found and factors which shape the nature and level of violence in schools.

A document based on an analysis of the voices of children who phoned childline from July – December 2000. It described the type of abuse reported by the children.

A community development project run over three years, with participatory research conducted in schools, homes, on the streets and with the police using self-administered questionnaires, interviews, focus groups and forum theatre to explore sexual violence. Many thousands of questionnaires were completed. The questionnaires were short, the household women’s questionnaire had 45 questions the first time and 30 for the re-survey. The youth questionnaire was 16 questions and mostly completed in classrooms.

Report of a meeting with stakeholders involved in virginity testing in KwaZulu Natal, human rights advocates and legal and medical experts. The report includes the text of speeches and a summary of discussions and the meeting’s conclusions.

News magazine website focusing on baby rape in the Philippines.

Research based on 14 focus group discussions in different parts of Namibia with learners aged 8-17 years and teachers.

_Department of Social Development (2001) Draft guidelines on notification of suspicions of possible ill treatment of or injury to children and of children suffering from nutritional deficiency diseases. (second draft) Department of Social Development, Pretoria._
This document outlines the administrative procedures related to special provisions on the protection of children and the notification of suspicions of ill treatment or injury to children

Cross-sectional sample of 1395 women aged 16-44 attending antenatal clinic and agreeing to HIV test. Data on the prevalence of sexual abuse before age 15 in this population and impact on risk of intimate partner violence and rape as an adult and risk of HIV infection. Study report in preparation will be distributed by the MRC Gender & Health Group from the second half of 2003.

_Foster, Lesley Ann. Masimanyane Women’s Support Center.  2000. “Violence against women: The problems facing South Africa.” www.ippf.org/resource/gbv/chogm99/foster.htm_ Study looked at experience of women reporting rape and domestic violence in the Greater East London area of South Africa. A series of cases were followed through East London and Mdantsane courts and their outcomes or problems encountered were reported.

Case series of 130 sexually abused children in the United Kingdom.

Consecutive case series of 109 sexually abused girl children in United Kingdom.

The study, undertaken in 2002 by the HSRC, MRC and CADRE to determine national HIV prevalence and behavioural risks. Interviews were conducted with 7 089 respondents aged 15 years and over and specimens for HIV testing were sought.

Article on prevalence, perpetrators of and socio-demographic risk factors for child rape based on a nationally representation sample of 11 375 women aged 15-49 interviewed about their experiences prior to age 15.

This report summarized and synthesized research findings on rape in South Africa, including the epidemiology of rape and sexual coercion, causal factors, and the criminal justice system. The paper has been derived from the report.


This presentation was from a pilot study with interviews with 150 men and 150 women (mean age 19 and 18 respectively). They were asked about experiences of different forms of sexual abuse and other traumas in childhood and the association between some of these and HIV status was calculated. These findings were from the pilot study of the Stepping Stones Study which is being conducted around Umtata and will have similar data on the lives of 2800 young men and women. It will report this in 2004.


Ethnographic study in Durban, in-depth interviews with 100 Zulu speaking youth aged 18-25. All were students and had at least one breadwinner in their home. Young people were asked what they would do if they found they had HIV and their perceptions of links between HIV and sexual violence.


This paper is based on ethnographic research in KwaZulu Natal, with interviews, participant observation and a review of literature and press cuttings.


Self-completed questionnaires from 414 Grade 9 and 10 students in three secondary schools in the Northern Province. The questionnaire asked about childhood sexual abuse and victim-perpetrator relationships.


Self-completed questionnaires from 414 Grade 9 and 10 students in three secondary schools in the Northern Province. Risk factors identified were ethnicity not being Pedi, a step-parent in the family in childhood, a mother who was employed but not as a labourer and violence at home.


Report based on newspaper cuttings, a review of documents and selected interviews with key players who have contact with children in sex work.


Reports a 1990 case series of 907 children under 12 treated in a STD clinic in Zimbabwe. Most of the children had been infected by neighbors or close relatives.

This paper was based on interviews with people living in neighbourhoods where gangs operated, interviews with youth on the fringes of gangs, political and civic activists and on court records of related cases.

Small qualitative study of child abuse in Swaziland.

Pilot study with 9000 school children who complete a short self-completion questionnaire on their attitudes towards and experiences of sexual violence.

Interviews with senior police officers and prosecutors in police stations and review of 1194 reported rape cases.

Research undertaken in North West Botswana on sexual harassment in secondary schools. 560 questionnaires were completed by students in junior and senior secondary schools and 78 completed by teachers.


This paper presents an analysis of 900 cases of sexual offences against children reported in Utah, United States of America.

Review of 887 case records held by Rape Crisis in Cape Town. No specific discussion of child sexual abuse cases.

Report of hearings held in Gauteng province on the criminal justice system’s performance when faced with child victims of sexual abuse. The report reviews the policy framework for responding to cases and rights of victims and reports on evidence submitted on the performance of the system when cases present. It concludes with extensive recommendations.

Varga CA (1997) Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu/Natal, South Africa. Health Transition Review Suppl 3, Vol7, 45-67. Ethnographic study of youth in Durban attending an antenatal clinic and men who had got teenage girls pregnant. Findings: violent male partners make their girlfriend fear to raise condoms and HIV protection with them; forced sex in relationships was very common with 71% of the 55% of girls who said they had attempted to refuse sex being forced.

Vogelman, Lloyd. 1990. The Sexual Face of Violence: Rapists on Rape. Johannesburg, South Africa: Raven Press Ltd. In depth study of rape in South Africa through the perspective of men, focusing on the social context, motivations, and feelings of “normal men” who rape. The study looked at 27 Coloured men divided into three groups, rapists, physically violent men, and non-violent men. Not all of the rapists had been convicted. Findings: rape reflects the masculine social and sexual role of dominance, power, and control or conquest; rape stems primarily from men’s need to live up to a cultural stereotype of masculinity.

Vundule C, Maforah F, Jewkes R, Jordaan E (2001) Risk factors for teenage pregnancy among African adolescents in metropolitan Cape Town: a case control study. South African Medical Journal. Jewkes R, Vundule C, Maforah F, Jordaan E (2001) Sexual dynamics in adolescent pregnancy. Social Science and Medicine. These two papers are written from a case control study of factors associated with teenage pregnancy. The first reports the key finding that teenagers who had had forced sexual initiation were 14 times more likely to subsequently get pregnant. The sexual paper draws on further data from the study to consider in more depth the meanings of ‘forcing’ at sexual initiation and to hypothesise the mechanisms through which the subsequent impact on reproductive health occurs.


These two papers discuss the same study, a qualitative study based on in-depth interviews with pregnant adolescents in Cape Town. The paper described violence and forced sex in their dating relationships and discusses the significance for sexual health interventions.

Paper discussing physical and sexual violence in the relationships and lives of 25 pregnant teenagers in Cape Town.

Paper presents quantitative data from a small (non-randomly selected) group of men on participation in gang rape and sets this in the context of a discussion of male view of gang rape derived from ethnographic research in Umtata.

Ethnographic research in Umtata with young men and women. This thesis was a product of 18 months field work. It contains a chapter on sexual coercion, setting the problem in the context of dating scripts, and a chapter on physical violence and HIV.

This is the report on the consultation on child sexual abuse.

This report considers the problem of violence by taking a public health approach. Each chapter is dedicated to a different form of violence and includes a definition, discussion of the magnitude of the problem globally, risk factors, health consequences and prevention strategies. There is a chapter on sexual violence and one on child abuse and neglect by parents and care givers.