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ABSTRACT

Child sexual abuse is a global phenomenon that occurs across cultures and socio-economic groupings with profound long-term physical and mental health consequences. Little is known about its prevalence and its treatment and prevention is under-researched. Globally, estimates show that between 7-37% of females and 5-10% of male children have experienced sexual abuse. In South Africa, one in six of all reported chronic sexual abuse cases is a girl under the age of 12 years. The social context of child sexual abuse in South Africa hinges on inequality and patriarchal constructions of masculinities which reinforces male dominance over women and girls, thereby increasing their vulnerability. Unequal power relations promote notions of male sexual entitlement and often lead to abuse without fear of its consequences. Parenting practices, harsh discipline, as well as the unwavering respect for elders all provide the space for such acts to occur without resistance. Although sexual violence is predominantly perpetrated by men against women and girls, sexual abuse of young boys is a growing concern internationally. Very little is known about the scale and nature of sexual abuse of boys, however, emerging research in South Africa estimate that one

in 10 men in adulthood, report having been sexually abused by other men. The consequences of sexual abuse of boys and girls can be severe, and may include Post-Traumatic Stress Disorder (PTSD) symptoms, depression, suicidal notions and attempts and inappropriate sexualised behaviour. The lack of an integrated service at health facilities and insensitive caregiver responses, as well as stigma of child sexual abuse, hampers access to effective treatment. Although South Africa has enabling legislation, policy frameworks and guidelines, these address sexual abuse mostly from a medico-legal perspective and do not address therapeutic responses to provide for the psycho-social or emotional needs of the child and his/her family. Limited resources and limited or lack of skills at health facilities in South Africa impact on the ability to deliver effective treatment. South Africa urgently requires a government-backed coherent, multi-sectoral response based on effective models of care in low economic settings to achieve effective long-term recovery for survivors.

Keywords: child sexual abuse, mental health consequences, multi-sectoral responses

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INTRODUCTION

Child sexual assault (CSA) is a pervasive problem that has affected the health, social and psychological wellbeing of children globally (Pinheiro, 2006). Yet, little is known about the prevalence of violence against children, and figures vary widely depending on the definitions used and how information is collected (Finkelhor, Turner, Ormrod, Hamby & Kracke, 2009; World Health Organization [WHO], 2006). Nevertheless, it is estimated that between 7-36% of female and 5-10% of male children have experienced sexual violence worldwide (Callender & Dartnall, 2010; Finkelhor, 1994; Jewkes, Penn-Kekana & Rose-Junius, 2005). Similarly, establishing the true extent of the CSA in South Africa is difficult, because police statistics is our main source of data; however, the under-reporting of rape suggests that prevalence estimates are grossly underestimated (Jewkes & Abrahams, 2002; Jewkes *et al.*, 2005). Given the extent of the problem and its public health impact, CSA is thought to impact on the lives of large numbers of children in Africa (Jewkes *et al.*, 2005; WHO, 2010).

Defining child sexual assault

Most definitions of child sexual abuse are limited and do not aptly define what constitutes sexual activity or sexual practise. In order to adequately define sexual assault, it is useful to explore definitions of sexual violence against adult women. The World Report on Violence and Health (WHO, 2002) has a definition of sexual violence against women which can be adapted to include children. The WHO report defines sexual violence as:

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise direct against women’s sexuality, using coercion (i.e. psychological intimidation, physical force or threats of harm), by a person, regardless of relationship to the victim, in any setting, including, but not limited to, home and work”. (WHO, 2002, p.149)

In addition, the WHO Consultation on Child Abuse Prevention (1999, p.15) has defined child abuse as:

“Child abuse or maltreatment constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power”.

A wide range of acts therefore encompass child sexual assault as the WHO (2002) report outlines:

- Rape and attempted rape, i.e. physically forced or coerced penetration of the vagina or anus with a penis or other body part or object.
- Coerced sexual activity through a spectrum of degrees of force.
- Sexual harassment, including sexual humiliation, unwanted sexual contact.
- Prostitution of children.
- Virginity testing.
- Female genital mutilation.
- Participation in pornographic performances or production of materials or exposure to pornography.

Violence and injuries are the second leading cause of death in South Africa, with social factors underpinning the perpetuation of violence (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009). Contributing social drivers of these high levels of violence include factors such as: poverty, patriarchal notions of masculinity, weak parenting and toxic childhoods, alcohol abuse and weakness in the law enforcement system, all resulting in CSA being a persistent problem (Seedat *et al.*, 2009). In South Africa’s Gauteng Province, statistics show that one in six of all rape cases reported to the police during 2003 are those of girls below the age of 12 years who have been chronically or repeatedly abused

(see Box) (Vetten *et al.*, 2008). Similarly, in the Eastern Cape, 39.1% of women and 16.7% of men report experiencing sexual abuse before the age of 18 (Jewkes, Dunkle, Nduna, Jama & Puren, 2010).

Children are most at risk of being assaulted by a person known to them (Makoae *et al.*, 2009; Townsend & Dawes, 2004). School settings in South Africa, as in many African countries, serve as a particular context in which sexual and physical violence are perpetrated against girls and boys (Morrell, 2001; Naker, 2005). Although policies are in place to protect children against exploitation and punishment, they lack adequate implementation (Morrell, 2001; Naker, 2005). Furthermore, very little is known about sexual violence against boys and young men. This gap in knowledge needs to be addressed in order to effectively respond to the needs of both boys and girls.

Child sexual abuse has a profound impact on the physical and mental health of its victims, with both immediate, as well as longer-term consequences and is of major concern (WHO, 2002). Health outcomes may include HIV infection, STIs, unwanted pregnancy, unsafe abortion and a range of adverse reproductive health consequences (Clark, Bruce & Dude, 2006; Mugawe & Powell, 2006; Neelofur-Khan, 2007). In South Africa, a study in the Eastern Cape has shown that neither boys nor girls who have experienced neglect and abuse are resilient against these forms of adversity. Longitudinal studies have shown that women who had experienced emotional, sexual or physical abuse in childhood are at increased risk of acquiring HIV, and the impact on mental health of children can be severe and pervasive (Jewkes *et al.*, 2010). Depression, suicidal thoughts and/or attempts, as well as alcohol and drug abuse have also been associated with emotional, physical and sexual abuse, both in women and men and have been widely documented (George & Norris, 2010; Jewkes *et al.*, 2010; Schraufnagel, Davis,

Sexual abuse reported in Gauteng Province in 2003

Sexual abuse reported in Gauteng Province in 2003 showed that girls between 0-11 years:

- Were twice as likely to be raped by friends/acquaintances and neighbours than were adult women.
- Were more likely to be raped in their own homes than either adolescent girls or adult women.
- Weapons were rarely used in violence against young girls. Coercion was mostly based on the authority or power of the perpetrator.
- Genital injuries were recorded in two out of three girls (65.3%) and teenagers' (66.2%) cases.
- Young girls were the group mostly told to keep quiet about the event. Abuse was mainly recognised through behavioural changes or psychological symptoms.
- Fifty five percent of young girls' cases led to an arrest, but only 22.1% went to trial and 10.1% resulted in a conviction.

Source: Vetten *et al.* (2008).

Shin, Hong & Hazen, 2010). In addition, research has shown that child abuse, as well as witnessing the abuse of a mother, carries a significant risk for developing psychopathology in childhood, adolescence and adulthood, including anti-social and violent behaviour, of which rape perpetration may be an outcome (Abrahams & Jewkes, 2005; Caspi *et al.*, 2002; Jewkes *et al.*, 2006b; Knight & Sims-Knight, 2003; Malamuth, 2003; Perry, 2001; Rutter & Taylor, 2002). The effects of abuse during early childhood have also shown to negatively affect the development of the brain, with consequent cognitive, psychological and social impairment (Navalta, Polcari, Webster, Boghossian & Teicher, 2006; Perry, 2001).

Research on treatment and preventative efforts remains largely underexplored and this is particularly true for the African region (WHO, 2010). A multi-country study in sub-Saharan Africa, by the Population Council developed, implemented and evaluated a comprehensive, multi-sectoral model to

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strengthen the evidence base on sexual and gender-based violence (SGBV) programming (Keesbury & Askew, 2010). Although this project increased the evidence base on programmes, further investigation is needed to improve comprehensive and effective responses to SGBV and CSA across the African continent (Keesbury & Askew, 2010; Lalor, 2004). This Chapter will focus on CSA in South Africa through a discussion of current knowledge, with the aim of identifying strategies to prevent and support girls and boys exposed to such forms of violence in their childhoods. We will:

- Explore the social context which provides the opportunity for such acts to occur.
- Discuss the mental health outcomes of CSA.
- Explore policy and programmatic implications.
- Present recommendations based on the evidence discussed in the Chapter.

THE SOCIAL CONTEXT OF CHILD SEXUAL ABUSE

CSA is a universal phenomenon that occurs across cultures and socio-economic groupings (Lalor, 2004). Understanding the social context which increases children's vulnerability and that provides the environment for such acts to occur is of importance if we hope to reduce its occurrence. Research on CSA has predominantly stemmed from high income settings with limited work from low to middle income countries, like South Africa (WHO, 2010). Whilst the research base is scant, the Report on Health and Violence in Africa suggests that the social context

creates conditions for CSA to be perpetuated, and increases the children's vulnerability to be victims of CSA (WHO, 2010). Societal and cultural norms related to the social position of children, child rearing practices, as well as the breakdown of immediate and extended family systems, orphaned children and child-headed households all contribute to children's vulnerability to CSA (WHO, 2010). Importantly, findings from ethnographic research conducted in South Africa and Namibia argue that a missing aspect of the discourse on CSA is the gendered nature of the act (Jewkes *et al.*, 2005).

CSA affects both girls and boys, although girls are particularly vulnerable due to their gendered position in South African society (Jewkes *et al.*, 2005), but very little is known about the sexual abuse of boys (see the Box on the next page). Dominant patriarchal constructions of masculinities in South Africa legitimate male control over women and children and promote notions of male sexual entitlement (Seedat *et al.*, 2009; Townsend & Dawes 2004). In some instances, sexual abuse is used as a means to punish a mother or the girl child, with rape used as a display of control (Jewkes *et al.*, 2005). Children are socialised to respect and to be obedient to their elders, with harsh methods of discipline still used to enforce parental control (Guma & Henda, 2004). This unquestionable authority of adults, allows for sexual violence to occur without much resistance from children (Townsend & Dawes, 2004). Teachers, in their position of authority, also hold significant

Table 1. Rape and indecent assault committed against children 2005-2008

	National Totals (adults and children)			Total Number of Children			Percentage Total for Children		
	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08	2005/06	2006/07	2007/08
Rape	54 926	52 617	36 190*	23 453	17 224*	16 068*	42.7%	32.7%	44.4%
Indecent assault	9 805	9 367	6 763*	4 726	4 581*	3 517*	48.2%	48.9%	52%

* Statistics relate to April–December for years 2006 and 2007

(Table adapted from RAPCAN Factsheet: Crimes Against Children, 2008)

power over school children, therefore, sexual abuse by teachers have been found to be a significant problem in South African schools (Abrahams, Jewkes, Laubscher & Hoffman, 2006; Brookes & Higson-Smith, 2004; Human Rights Watch, 2001). These unequal power relations, thus, provide men with the space to sexually abuse children.

Perpetrators are mainly male adults and youth who are known to the child, in particular relatives and acquaintances (Makoe *et al.*, 2009). Limited research has been conducted with perpetrators in South Africa. Such studies suggest that perpetrators are more likely to have a history of childhood sexual or physical abuse, as well as witnessing the violence towards their mothers (Townsend & Dawes, 2004). An international review and meta-analysis of risk factors for perpetration of CSA found that a history of sexual abuse, harsh discipline as a child, and difficulty with intimate relationships, antisocial behaviour and loneliness were found to be positively associated (Whitaker *et al.*, 2008). In addition, the only major difference between perpetrators of CSA and adult sexual assault were found to be higher levels of externalising behaviours (Whitaker *et al.*, 2008). Nevertheless, large numbers of abusers are not apprehended due to silence from children and communities continuing the cycle of CSA (Townsend & Dawes, 2004).

The responsiveness of the social welfare sector, regarding the protection of vulnerable children, and the criminal justice system in punishing perpetrators are important features of societal responses to CSA (Jewkes *et al.*, 2005, Richter & Dawes, 2008). In a study on the attrition of rape cases in Gauteng, it was found that 45.5% of cases of young girls were dropped by the prosecution (Vetten *et al.*, 2008). This study also points to the police's failure to protect children from further victimisation and intimidation. Furthermore, it is argued that the social services sector lacks the capacity to respond adequately to protect children (Loffel, Allsopp & Atmore, 2008). The need for services far outweighs the capacity

Sexual abuse and coercion of boys

Sexual abuse of boys is not a new phenomenon. Yet, globally very little is known about the nature and extent of sexual violence against boys (Barker & Ricardo, 2006; Finkelhor *et al.*, 2009). In South Africa sexual assault of boys has mainly been investigated in prison settings (Achmat, 1993; Gear, 2005; Steinberg, 2006). The paucity of literature on sexual abuse of boys in the general population has led to an assumption that it rarely occurs (Lalor, 2004). Hence, it has mainly been conceptualised as forcible sodomy and approached from a moral perspective rather than a public health discourse. While scant, South African research has shown that sexual abuse of boys by men has serious health consequences, such as an increased risk of contracting HIV and mental health problems, including alcohol abuse (Jewkes *et al.*, 2006, Jewkes, Sikweyiya, Morrell, & Dunkle 2009, Jewkes *et al.*, 2010).

South African studies have mainly aimed to determine the magnitude of the problem. A survey with students in the Northern Province estimate that 8.8% of males experienced sexual abuse (Madu, 2001). Similarly a general population survey with men in KwaZulu-Natal and Eastern Cape estimate that nearly 10% of men have been forced into sex (Jewkes *et al.*, 2009). Significantly, this study established that CSA was more common for men who reportedly rape (Jewkes *et al.*, 2009). One of the few qualitative studies, conducted in the rural Eastern Cape broadened our understanding of the sexual abuse of young boys within a rural context (Sikweyiya & Jewkes, 2009). The lack of adult supervision due to duties, such as herding place boys in remote settings, increasing the risk for young boys' to be physically bullied and forced into sex (Sikweyiya & Jewkes, 2009). Importantly this study highlighted the context of sexual coercion by women, is markedly different. Such acts often occurs in the safety of the boy's home and female perpetrators were commonly older lodgers, domestic helpers and family friends who subjected boys to unwanted touching or exposed themselves, culminating in persuasion to have sex (Sikweyiya & Jewkes, 2009). The majority of such acts of abuse by men and women were not disclosed to families or friends or reported to the police (Sikweyiya & Jewkes, 2009). Given the high rates of non-disclosure it is anticipated that rates of sexual assault of boys is likely to be much higher than estimated.

of the social services sector to respond adequately, with only 5063 social workers employed to deliver services during 2005 (Loffel *et al.*, 2008).

MENTAL HEALTH CONSEQUENCES

The mental health effects of CSA are profound, as the perpetrator is most likely someone known to the child and the abuse manifests in a relationship

Case study

A 17-year old living with her aunt was raped at a school dance while intoxicated. This was her second experience of rape. The first incident occurred when she was 9 years old, in the care of her grandmother and raped by an uncle. She required surgery after the first incident and was seen by a social worker while in hospital, with no further follow-up from social services after her discharge. At 16 she was sent to live with an aunt in Cape Town from a rural town, as her grandmother was aging and could no longer “manage” her. Her mother had abandoned her in the paternal grandmother’s care as an infant. With this latest incident she was not referred for counselling to a sexual assault centre. She is now displaying behavioural problems and inappropriate emotional affect.

of trust and affection. It is well documented that CSA is associated with an increased risk for long-term psychological sequelae which can continue and impact on adult functioning (Hyman, Gold & Cott 2003; Maniglio, 2009). Evidence has shown that child victims are at increased risk of depression, anxiety, dissociation and PTSD (Maniglio, 2009). CSA is also associated with an increase in behavioural problems, sexual risk behaviour as well as re-victimisation of the child (Maniglio, 2009). A range of psychological and social factors contribute to the development of psychopathology, particularly family dysfunction is associated with negative psychological outcomes (Briere & Elliot, 1993). While other factors such as gender, age when abused, type and severity of abuse, cognitive abilities, and relationship to the perpetrator also influence the child’s immediate and long-term mental health response to victimisation (Maniglio, 2009). In a longitudinal follow-up study

with children to explore their psycho-social needs post-rape at two sexual assault centres in the Western Cape, it was found that just under half of the children (43.3%) still presented with full symptom PTSD 4-6 months after first presentation at a sexual assault centre (Mathews, 2009). In addition, this study found that most children did not disclose immediately, with the majority fearing the response of parents and caregiver and expecting to be blamed (Mathews, 2009).

The impact of CSA can be understood in terms of who the perpetrator is, the duration of the abuse and the age of the child at onset and responses to disclosure (Killian & Brakarsh, 2004). For some children this trauma is internalised and they present with severe psychosomatic responses, like headaches, stomach aches, and loss of appetite before disclosure (Maniglio, 2009; Polusny & Follette 1995). Factors such as parent-child relationship and family functioning also play an important role in how a child adjusts post-rape, as this directly affects the support the child receives post-disclosure (Briere & Elliot 1993; Hunter, 2006). These factors have been shown to be particularly pronounced during the adolescent phase, with caregivers more likely to blame the child and thus influence recovery (Bergen, Martin, Richardson, Allison & Roeger, 2004).

Psychological support to deal with this trauma effectively is extremely important particularly to assist the child and the family deal with their initial reaction to the assault (Foa & Rothbaum, 1998; Resnick *et al.*, 2007). It is critical to establish the safety of the child from the outset (Callender & Dartnall, 2010). In the high income world, psychological debriefing and cognitive behaviour therapy is primarily used to reduce the effect of trauma, in the aftermath of an assault (Litz, Gray, Bryant & Adler, 2002). The child’s response in the first four weeks post-assault is considered a good indicator of long-term mental health prognosis (Mcnally, Bryant & Ehlers, 2003; Resnick, Acierno, Holmes, Kilpatrick

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& Jager, 1999). The Western Cape CSA study found that the majority of children do not receive post-rape counselling or other forms of psychotherapy; although some were referred for psychological support with 43% of children still meeting the criteria for full symptom PTSD (Mathews, 2009). Logistical barriers and the lack of an integrated service at health facilities is a challenge many children and their families face to access counselling independently (Mathews, 2009). In addition, the response of caregivers to the rape also impacts on the child's recovery. Rape of children is extremely traumatic for parents, and is compounded by the parent's experiences of trauma, which is common in the South African setting (Seedat, Nyamai, Njenga,

Vythilingum & Stein, 2004). This has a major impact on parents' emotional availability and ability to assist in the child's recovery. In high income countries it has been found that children's emotional and behavioural adjustment following CSA is associated with parental reaction and the emotional support they receive from parents (Elliot & Carnes, 2001). The inclusion of both the child and the caregiver in counselling is an important strategy to enhance mental health adjustment. Understanding what constitutes an effective mental health response to CSA in low-resourced settings are just emerging (Keesbury & Askew, 2010). Internationally, very few interventions have been rigorously evaluated to assess effectiveness. In low resourced settings

Commercial sexual exploitation of children

In 1996, the South African Government pledged commitment to the Stockholm Agenda for Action to work towards the reduction and elimination of commercial sexual exploitation of children which includes prostitution, trafficking and child pornography (Ecpat International, 2007). In addition South Africa ratified the Palermo Protocol to Prevent, Suppress and Punish Trafficking in persons especially Women and Children which serves to supplement the United Nations Convention against Transnational Organised Crime (United Nations, 2004; Human Sciences Research Council [HSRC], 2010). Despite these commitments current legislation aimed at combating trafficking is fragmented and is addressed in the Sexual Offences Amendment Act, while children are specially protected by the Children's Act (HSRC, 2010). To meet their international obligations the South African government has introduced the Combating of Trafficking in Persons Bill which is currently under discussion.

Reliable data on crimes against children such as sex tourism, child pornography and related cyber crimes in South Africa is limited and available data and anecdotal evidence suggests that such crimes are steadily increasing (Ecpat International, 2007; HSRC, 2010). South Africa has been found to be a main destination for southern Africa and victims are often recruited by coercion, force and trickery

(Kreston, 2007). Adequate support of trafficked women and children is an area which needs serious attention and although South Africa was removed from the 2009 US Department of State Watch List, more effort is needed to adequately address this problem. Limitations to do so is compounded by a lack of national research data and the recent HSRC Tsireledzani report (2010) shows that there is currently progress from the non-governmental sector and certain government departments to develop and identify legislative measures and policy responses to counter trafficking in South Africa. These responses were possibly to bring South Africa in line with their obligation of developing a national action plan as the minimum standard of the Palermo Protocol. A Trafficking in Persons Intersectoral Task Team which includes civil society, non-governmental agencies, government departments, law enforcement and justice departments as well as international organisations was established. The purpose of the Task Team is to develop a National Action plan thus facilitating an intersectoral response to this end. From the efforts seen in the different sectors it is clear that South Africa is starting to make great strides in the prevention of trafficking for sexual exploitation. It is important that these efforts include systematic and standardised research methodologies in order to succeed in the development of appropriate measures to protect South Africa's children.

it has been recommended that psychological interventions should target those with prolonged symptomatology to prevent the development of chronic symptomatology (Callender & Dartnall, 2010). Cognitive behaviour therapy (CBT) with children and their parents have empirically been shown as effective in treating the trauma associated with CSA (Kaminer, Seedat & Stein, 2005). Given the under-resourcing and under-development of mental health services in South Africa, further research is needed to determine how best to provide psychological support and treatment effectively and sustainably for survivors in public health services.

PROGRAMMING AND POLICY INITIATIVES IN SOUTH AFRICA

South Africa has recently undergone a legislative reform process aimed to provide children with increased protection and to bring South Africa's child policy framework in line with our constitutional and international obligations. These key pieces of legislation, the Sexual Offences Act No 32 of 2007, the Children's Act No 38 of 2005 and the Children's Amendment Act No 41 of 2007 have all been introduced to strengthen the South African child protection system. The Sexual Offences Act no 32 of 2007 broadens the definition of rape, thus recognising the rape of boys (anal sex) as well as acknowledging a wide range of non-penetrative acts as sexual assault. It also makes provision for specialised courts, Thuthuzela Care Centres and national policy guidelines for victims of sexual offences. The policy framework introduces the concept of one-stop integrated services, but fails to introduce specialised services for child survivors of sexual assault. It, however, addresses CSA from a medico-legal perspective and lacks a therapeutic response and does not provide for the psycho-social or emotional needs of the child and its family.

The Children's Amendment Act No 41 of 2007 provides the framework for psychological,

rehabilitative and therapeutic services for abused children, but key to the effectiveness of this legislation is the appropriate resources for the act to be fully implemented (Proudlock & Jamieson, 2008). Due to the nature of CSA, child protection requires an integrated collaborative response from social services, the police, the courts, medico-legal services, health care services and education, as all these sectors are important in preventing and managing CSA with the aim of effectively protecting the child. Although child protection is a statutory function, historically, child protection services were primarily delivered by the non-government sector with large gaps in services, particularly in rural areas with shortages of skilled staff and resources (CASE, 2005). Despite the huge public health burden, services have primarily been focused on statutory processes, with alternative care used as a mechanism to ensure children's safety (Loffel, 2004).

Internationally, it has been proposed to effectively address CSA it has to be managed in specialised units functioning with a multi-disciplinary team (Killian & Brakarsh, 2004; Maniglio, 2009). This model is based on the notion that the victim requires long-term therapy and it is therefore resource intensive. The challenge facing South Africa is the provision of effective services within a large diverse population (Higson-Smith, Lamprecht & Jacklin, 2004). A review of mental health responses for victims of sexual assault proposes that models of care should focus on the prevention of long-term psychological sequelae (Callender & Dartnall 2010). Limited resources should target those who present with symptoms after the first month to prevent the development of chronic symptoms, through psychotherapeutic treatments based on the needs of individual children and their families (Resnick *et al.*, 1999). A few best-practice models exist in South Africa, an example is the Teddy Bear Clinic located in the urban area of Johannesburg with this model based on the multi-disciplinary team approach, offering

a range of services with an emphasis on medico-legal and therapeutic services to children and their parents (Higson-Smith *et al.*, 2004). Specialist services in South Africa are, however, still limited as it is predominantly accessible only to those living in urban areas (Higson-Smith *et al.*, 2004). In addition, the Children's Act of 2005 provides for the mandatory reporting and registration of child abuse, which is intended to function at a national level in order to provide national data on patterns and trends to assist in planning (Richter & Dawes, 2008). Whether this is the appropriate strategy, given our budgetary constraints and limited resources, has been questioned (Loffel, 2004) as it can only be effective in partnership with well resourced child protection services that are monitored and evaluated (Richter & Dawes, 2008).

Although we have enabling legislation, policies and guidelines, there is a lack of a comprehensive national child protection strategy and dedicated resources to support its implementation. We urgently require a coherent multi-sectoral strategy to co-ordinate CSA within the ambit of child protection, with the aim of facilitating adequate resource allocation, prevent duplication, and to provide appropriate and effective long-term management across and between sectors.

CONCLUSIONS

CSA has been shown to affect large numbers of both girls and boys, with social context playing an important role in providing the space for such acts to occur. In order to prevent the sexual abuse of children it is imperative that we address the broader social context; such as improving the status of children as well as the position of women in South African society. The patriarchal nature of our society legitimises men's position of power and their control over women and children, thus changing gender relations are key to shifting patterns of CSA. Furthermore, the composition of families and parent-child relationships also increases the vulnerabilities

Key messages

- The social context plays an important role in increasing children's vulnerability and provides the space for child sexual abuse of both girls and boys to occur.
- CSA is predominantly perpetrated by men against girls, but it is important that we acknowledge that boys are also victims of child sexual abuse and requires further exploration.
- Dominant patriarchal constructions of masculinities in South Africa legitimate male control over women and children and promote notions of male sexual entitlement and provide the context for acts of sexual abuse of both girls and boys.
- A marked contrast exists when boys are coerced into sex by men compared to women, with acts of coercion by women framed as temptation and viewed as means to prove their manhood.
- The ability of social welfare and criminal justice sector to respond adequately to protect children increases their vulnerability for ongoing child sexual abuse.
- The trauma of child sexual abuse can be internalised with long-term mental health consequences such as PTSD, with trauma counselling vital in the post rape period to facilitate post-rape recovery.

of children. Strengthening families and parenting practices is important in preventing not only CSA but also in assisting with recovery to reduce the long-term consequences. Importantly, advocating for improved services to children and their families after acts of sexual assault is critical. The long-term consequences are enormous and current responses are inadequate. Post-rape counselling needs to incorporate both the caregiver and the child as both needs assistance to deal with the trauma of sexual assault. What constitutes an effective response to CSA requires further exploration, but a comprehensive integrated service addressing both the health, psycho-social and legal needs of the child and its family is imperative to facilitate healing.

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